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If you wish to add or make changes to your insurance coverage(s), please consult a Benefits Representative during your scheduled enrollment period. **You will not be able to make any changes once the enrollment period is over** unless you experience a qualified event outlined by the IRS (i.e., marriage, divorce, birth of a child, etc.) If you should experience a qualified event, you have 30 days from the date of the event to make any changes.

All information in this booklet is a brief description of your coverage and is not a contract. Please refer to your policy or certificate for each product for the exact terms and conditions.

## Duplin County: PPO

Coverage Period: 07/01/2014 - 06/30/2015

### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage for:** Individual/Family **Plan Type:** PPO

**!** **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsnc.com](http://www.bcbsnc.com) or by calling **1-877-275-9787**.

Important Questions	Answers	Why this Matters:
<p><b>What is the overall <u>deductible</u>?</b></p>	<p><b>\$2,000</b> person/<b>\$4,000</b> family for in-network; <b>\$4,000</b> person/<b>\$8,000</b> family for out-of-network. Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to the deductible.</p>	<p>You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b>.</p>
<p><b>Are there other <u>deductibles</u> for specific services?</b></p>	<p>Yes. \$100 for prescription drugs.</p>	<p>You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.</p>
<p><b>Is there an <u>out-of-pocket limit</u> on my expenses?</b></p>	<p><b>Yes. \$4,000</b> person/<b>\$10,000</b> family for in-network; <b>\$8,000</b> person/<b>\$20,000</b> family for out-of-network</p>	<p>The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>
<p><b>What is not included in the <u>out-of-pocket limit</u>?</b></p>	<p>Penalties for failure to obtain pre-authorizations for services, Premiums, balance-billed charges, pharmacy expenses, and health care this plan doesn't cover</p>	<p>Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b>.</p>
<p><b>Is there an overall annual limit on what the plan pays?</b></p>	<p>No.</p>	<p>The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.</p>

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://ccio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.

<p><b>Does this plan use a <a href="#">network of providers</a>?</b></p>	<p>Yes. For a list of In-Network providers, see <a href="http://www.bcbsnc.com/content/providersearch/index.htm">www.bcbsnc.com/content/providersearch/index.htm</a> or please call 1-877-275-9787</p>	<p>If you use an in-network doctor or other health care <a href="#">provider</a>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <a href="#">provider</a> for some services. Plans use the term in-network, <a href="#">preferred</a>, or participating for <a href="#">providers</a> in their <a href="#">network</a>. See the chart starting on page 2 for how this plan pays different kinds of <a href="#">providers</a>.</p>
<p><b>Do I need a referral to see a <a href="#">specialist</a>?</b></p>	<p>No. You don't need a referral to see a specialist.</p>	<p>You can see the <a href="#">specialist</a> you choose without permission from this plan.</p>
<p><b>Are there services this plan doesn't cover?</b></p>	<p>Yes.</p>	<p>Some of the services this plan doesn't cover are listed on a later page. See your policy or plan document for additional information about <a href="#">excluded services</a>.</p>

-  • [Copayments](#) are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- [Coinsurance](#) is *your* share of the costs of a covered service, calculated as a percent of the [allowed amount](#) for the service. For example, if the plan's [allowed amount](#) for an overnight hospital stay is \$1,000, your [coinsurance](#) payment of 20% would be \$200. This may change if you haven't met your [deductible](#).
- The amount the plan pays for covered services is based on the [allowed amount](#). If an out-of-network [provider](#) charges more than the [allowed amount](#), you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the [allowed amount](#) is \$1,000, you may have to pay the \$500 difference. (This is called [balance billing](#).)
- This plan may encourage you to use in-network [providers](#) by charging you lower [deductibles](#), [copayments](#) and [coinsurance](#) amounts.

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<p><b>If you visit a health care <a href="#">provider's</a> office or clinic</b></p>	<p>Primary care visit to treat an injury or illness</p>	<p>\$30/visit</p>	<p>40% Coinsurance</p>	<p>---none---</p>
	<p>Specialist visit</p>	<p>\$60/visit</p>	<p>40% Coinsurance</p>	<p>---none---</p>

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Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you have a test</b>  <b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.bcbsnc.com/content/services/formulary/presdrugben.htm">prescription drug coverage</a> is available at <a href="http://www.bcbsnc.com/content/services/formulary/presdrugben.htm">http://www.bcbsnc.com/content/services/formulary/presdrugben.htm</a>	Other practitioner office visit	\$60/Chiropractic Visit	40% Coinsurance/Chiropractic Visit	-- Coverage is limited to 30 visits for Chiropractic care.
	Preventive care/screening/immunization	No Charge	Not Covered	-- Limits may apply
	Diagnostic test (x-ray, blood work)	0% Coinsurance	40% Coinsurance	-- No coverage for tests not ordered by a doctor.
	Imaging (CT/PET scans, MRIs)	\$100/visit	40% Coinsurance	-- Prior authorization may be required or services will not be covered.
	Generic drugs	\$4/prescription; \$8/prescription mail order	\$4/prescription	-- No coverage for drugs in excess of quantity limits or therapeutically equivalent to an over the counter drug.
	Preferred brand drugs	\$45/prescription; \$90/prescription mail order	\$45/prescription	Same as above
	Non-preferred brand drugs	\$60/prescription; \$120/prescription mail order	\$60/prescription	Same as above
	Specialty drugs	25% Coinsurance with min/max copay	25% Coinsurance with min/max copay	-- Coverage is limited to a 30 day supply. You pay up to \$100 maximum.
	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	40% Coinsurance	---none---
	Physician/surgeon fees	30% Coinsurance	40% Coinsurance	---none---

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Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need immediate medical attention</b>	Emergency room services	\$500/visit	\$500/visit	---none---
	Emergency medical transportation	30% Coinsurance	30% Coinsurance	---none---
	Urgent care	\$60/visit	\$60/visit	---none---
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	-Precertification may be required
	Physician/surgeon fee	30% Coinsurance	40% Coinsurance	---none---
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$60/office visit; 30% Coinsurance	40% Coinsurance	Prior Authorization may be required
	Mental/Behavioral health inpatient services	30% Coinsurance	40% Coinsurance	Precertification required
	Substance use disorder outpatient services	\$60/office visit; 30% Coinsurance	40% Coinsurance	Prior Authorization may be required
	Substance use disorder inpatient services	30% Coinsurance	40% Coinsurance	Precertification required
	Prenatal and postnatal care	30% Coinsurance	40% Coinsurance	---none---
<b>If you are pregnant</b>	Delivery and all inpatient services	30% Coinsurance	40% Coinsurance	Precertification may be required
	Home health care	30% Coinsurance	40% Coinsurance	-- Prior authorization required or services will not be covered
<b>If you need help recovering or have other special health needs</b>	Rehabilitation services	30% Coinsurance	40% Coinsurance	-- Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined for OT/PT/Chiropractic and 30 visits per benefit period for Speech Therapy

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Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If your child needs dental or eye care</b>	Habilitation services	30% Coinsurance	40% Coinsurance	-- Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined for OT/PT/Chiropractic and 30 visits per benefit period for Speech Therapy
	Skilled nursing care	30% Coinsurance	40% Coinsurance	-- Coverage is limited to 60 visits per benefit period.-- Precertification required
	Durable medical equipment	30% Coinsurance	40% Coinsurance	-- Prior authorization may be required for benefits to be provided-- Limits may apply
	Hospice services	30% Coinsurance	40% Coinsurance	-- Precertification may be required
	Eye exam	No Charge	Not Covered	Annual limits apply
	Glasses	Not Covered	Not Covered	Excluded Service
	Dental check-up	Not Covered	Not Covered	Excluded Service

\*HSA/HRA funds, if available, may be used to cover eligible medical expenses

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## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other [excluded services](#).)

- Acupuncture
- Hearing aids up to age 22
- Weight loss programs
- Cosmetic surgery and services
- Long-term care, respite care, rest cures
- Dental care (Adult)
- Routine Foot Care

\*HSA/HRA funds, if available, may be used to cover eligible medical expenses

\*\*Self-funded groups may cover this service; check your benefit booklet for details

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Non-emergency care when traveling outside the U.S. (PPO). Coverage provided outside the United States. See [www.bcbsnc.com](http://www.bcbsnc.com)
- Termination of Pregnancy
- Chiropractic care
- Private duty nursing
- Infertility treatment
- Routine eye care (Adult)

\*\*\*Self-funded groups may not cover this service; check your benefit booklet for details

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## **Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact BCBSNC at 1-877-275-9787. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## **Your Grievance and Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: BCBSNC at 1-877-275-9787 or [mybcbsnc.com](http://mybcbsnc.com). You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), if applicable.

## **Does This Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

## **Does This Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of health plan. **The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.**

\*Please note that although amounts contributed by an employer to an employee's HSA or integrated HRA should be taken into account for this calculation, the amount of that contribution, if unknown, has not been considered.

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## Language Access Services:

Spanish (Español): Para obtener asistencia en español, llame al número que aparece al respaldo de su tarjeta del seguro.

Tagalog (Tagalog): Para matulungan sa Tagalog, tawagan ang numerong nasa likuran ng insurance card.

Chinese (中文): 如蒙國語或廣東話協助，請致電您保險卡背面的電話號碼。

Navajo (Dine): Diné bizaad bee shika'adoowol ninzingo kwoji' hólné', naaltsoos áłts'ísí nantinígí' bine'déé' binámboo bikáá'.

-----To see examples how this plan might cover costs for a sample medical situation, see the next page -----

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$3,900
- **You pay** \$3,600

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$2,000
Copays	\$40
Coinsurance	\$1,400
Limits or exclusions	\$200
<b>Total</b>	<b>\$3,600</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,100
- **Plan pays** \$3,600
- **You pay** \$1,500

#### Sample care costs:

Prescriptions	\$2,700
Medical Equipment and Supplies	\$1,200
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,100</b>

#### Patient pays:

Deductibles	\$700
Copays	\$400
Coinsurance	\$300
Limits or exclusions	\$50
<b>Total</b>	<b>\$1,500</b>

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## Questions and answers about Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box for each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should consider also contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HIRAs) that help you pay out-of-pocket expenses.

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## Duplin County: H S A

Coverage Period: 07/01/2014 - 06/30/2015

### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage for:** Individual/Family **Plan Type:** PPO

**!** **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsnc.com](http://www.bcbsnc.com) or by calling **1-877-275-9787**.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	<b>\$1,500</b> person/ <b>\$3,000</b> family for in-network; <b>\$3,000</b> person/ <b>\$6,000</b> family for out-of-network. Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to the deductible.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	<b>Yes. \$3,500</b> person/ <b>\$5,000</b> family for in-network; <b>\$7,000</b> person/ <b>\$10,000</b> family for out-of-network	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the out-of-pocket limit?</b>	Penalties for failure to obtain pre-authorizations for services, Premiums, balance-billed charges, copayments and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a network of providers?</b>	Yes. For a list of In-Network providers, see <a href="http://www.bcbsnc.com/content/">www.bcbsnc.com/content/</a>	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term

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	providersearch/index.htm or please call 1-877-275-9787	in-network, <b><u>preferred</u></b> , or participating for <b><u>providers</u></b> in their <b><u>network</u></b> . See the chart starting on page 2 for how this plan pays different kinds of <b><u>providers</u></b> .
<b>Do I need a referral to see a <u>specialist</u>?</b>	No. You don't need a referral to see a specialist.	You can see the <b><u>specialist</u></b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on a later page. See your policy or plan document for additional information about <b><u>excluded services</u></b> .

- !**
- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
  - **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
  - The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
  - This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	30% Coinsurance	50% Coinsurance	---none---
	Specialist visit	30% Coinsurance	50% Coinsurance	---none---

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Other practitioner office visit	30% Coinsurance/Chiropractic Visit	50% Coinsurance/Chiropractic Visit	-- Coverage is limited to 30 visits for Chiropractic care.
	Preventive care/screening/immunization	No Charge	50% Coinsurance	-- Limits may apply
	Diagnostic test (x-ray, blood work)	30% Coinsurance	50% Coinsurance	-- No coverage for tests not ordered by a doctor.
<b>If you have a test</b>	Imaging (CT/PET scans, MRIs)	30% Coinsurance	50% Coinsurance	-- Prior authorization may be required or services will not be covered.
	Generic drugs	30% Coinsurance	30% Coinsurance	-- No coverage for drugs in excess of quantity limits or therapeutically equivalent to an over the counter drug.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.bcbsnc.com/content/services/formulary/presdrugben.htm">prescription drug coverage</a> is available at <a href="http://www.bcbsnc.com/content/services/formulary/presdrugben.htm">http://www.bcbsnc.com/content/services/formulary/presdrugben.htm</a>	Preferred brand drugs	30% Coinsurance	30% Coinsurance	Same as above
	Non-preferred brand drugs	30% Coinsurance	30% Coinsurance	Same as above
	Specialty drugs	30% Coinsurance	30% Coinsurance	-- Coverage is limited to a 30 day supply.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	50% Coinsurance	---none---
	Physician/surgeon fees	30% Coinsurance	50% Coinsurance	---none---

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Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need immediate medical attention</b>	Emergency room services	30% Coinsurance	30% Coinsurance	---none---
	Emergency medical transportation	30% Coinsurance	30% Coinsurance	---none---
	Urgent care	30% Coinsurance	30% Coinsurance	---none---
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	-Precertification may be required
	Physician/surgeon fee	30% Coinsurance	50% Coinsurance	---none---
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	30% Coinsurance	50% Coinsurance	Prior Authorization may be required
	Mental/Behavioral health inpatient services	30% Coinsurance	50% Coinsurance	Precertification required
	Substance use disorder outpatient services	30% Coinsurance	50% Coinsurance	Prior Authorization may be required
	Substance use disorder inpatient services	30% Coinsurance	50% Coinsurance	Precertification required
	Prenatal and postnatal care	30% Coinsurance	50% Coinsurance	---none---
<b>If you are pregnant</b>	Delivery and all inpatient services	30% Coinsurance	50% Coinsurance	Precertification may be required
	Home health care	30% Coinsurance	50% Coinsurance	-- Prior authorization required or services will not be covered
<b>If you need help recovering or have other special health needs</b>	Rehabilitation services	30% Coinsurance	50% Coinsurance	-- Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined for OT/PT/Chiropractic and 30 visits per benefit period for Speech Therapy

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If your child needs dental or eye care</b>	Habilitation services	30% Coinsurance	50% Coinsurance	-- Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined for OT/PT/Chiropractic and 30 visits per benefit period for Speech Therapy
	Skilled nursing care	30% Coinsurance	50% Coinsurance	-- Coverage is limited to 60 visits per benefit period.-- Precertification required
	Durable medical equipment	30% Coinsurance	50% Coinsurance	-- Prior authorization may be required for benefits to be provided-- Limits may apply
	Hospice services	30% Coinsurance	50% Coinsurance	-- Precertification may be required
	Eye exam	No Charge	50% Coinsurance	Annual limits apply
	Glasses	Not Covered	Not Covered	Excluded Service
	Dental check-up	Not Covered	Not Covered	Excluded Service

\*HSA/HRA funds, if available, may be used to cover eligible medical expenses

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## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Hearing aids up to age 22
- Weight loss programs
- Cosmetic surgery and services
- Long-term care, respite care, rest cures
- Dental care (Adult)
- Routine Foot Care

\*HSA/HRA funds, if available, may be used to cover eligible medical expenses

\*\*Self-funded groups may cover this service; check your benefit booklet for details

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Non-emergency care when traveling outside the U.S. (PPO). Coverage provided outside the United States. See [www.bcbsnc.com](http://www.bcbsnc.com)
- Termination of Pregnancy
- Chiropractic care
- Private duty nursing
- Infertility treatment
- Routine eye care (Adult)

\*\*\*Self-funded groups may not cover this service; check your benefit booklet for details

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://ccio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.

## **Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact BCBSNC at 1-877-275-9787. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## **Your Grievance and Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: BCBSNC at 1-877-275-9787 or [mybcbsnc.com](http://mybcbsnc.com). You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), if applicable.

## **Does This Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

## **Does This Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of health plan. **The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.**

\*Please note that although amounts contributed by an employer to an employee's HSA or integrated HRA should be taken into account for this calculation, the amount of that contribution, if unknown, has not been considered.

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.

## Language Access Services:

Spanish (Español): Para obtener asistencia en español, llame al número que aparece al respaldo de su tarjeta del seguro.  
Tagalog (Tagalog): Para matulungan sa Tagalog, tawagan ang numerong nasa likuran ng insurance card.  
Chinese (中文): 如蒙國語或廣東話協助，請致電您保險卡背面的電話號碼。  
Navajo (Dine): Diné bizaad bee shika'adoowol ninzingo kwoji' hólné', naaltsoos áłts'ísí nantinígí' bine'déé' binámboo bikáá'.

-----To see examples how this plan might cover costs for a sample medical situation, see the next page -----

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$4,200
- **You pay** \$3,300

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$1,500
Copays	\$0
Coinsurance	\$1,600
Limits or exclusions	\$200
<b>Total</b>	<b>\$3,300</b>

### Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,100
- **Plan pays** \$2,500
- **You pay** \$2,600

#### Sample care costs:

Prescriptions	\$2,700
Medical Equipment and Supplies	\$1,200
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,100</b>

#### Patient pays:

Deductibles	\$1,500
Copays	\$0
Coinsurance	\$1,000
Limits or exclusions	\$50
<b>Total</b>	<b>\$2,600</b>

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://ccio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.

## Questions and answers about Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box for each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should consider also contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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<b>PPO MONTHLY RATES</b>	
<b>Employee Only</b>	<b>\$0.00</b>
<b>Employee + 1 Dependent</b>	<b>\$212.00</b>
<b>Employee + Family</b>	<b>\$495.00</b>

<b>HSA MONTHLY RATES</b>	
<b>Employer HSA Contribution - \$750</b>	
<b>Employee Only</b>	<b>\$0.00</b>
<b>Employee + 1 Dependent</b>	<b>\$212.00</b>
<b>Employee + Family</b>	<b>\$495.00</b>

# Gilsbar Flexible Spending Accounts

**Plan Year: July 1, 2014 - June 30, 2015**

**Medical Reimbursement Plan Maximum: \$2,400**

**Dependent Care Account Maximum: \$5,000**

**Run-out Period: 90-days following end of plan year**



Thank you for choosing to participate in the Health Care or Dependent Care FSA. Your plan is administered by Gilsbar, LLC. County of Duplin's Group Number is S2536

## **MANAGE YOUR ACCOUNT ONLINE 24/7 AT [WWW.MYGILSBAR.COM](http://WWW.MYGILSBAR.COM)!**

- Check your up-to-the-minute plan balances
- View election amounts and reimbursement details
- File claims and submit receipts online

## **THERE IS A HANDY MOBILE APPLICATION!**

- Access available account balances on your iPhone®, iPod Touch®, iPad®, or Android®-powered device
- Submit claims and receipts using your device's camera
- Receive selected alerts via text message on any mobile device

## **IT'S EASY TO GET STARTED:**

**STEP 1:** After your effective date, go to [www.myGilsbar.com](http://www.myGilsbar.com) and register as a new participant. You will complete a brief registration form, and you will need a valid e-mail address and your Group Number, S2536.

**STEP 2:** Once logged in, choose the *FSAs and HRAs* link in the left navigation bar.

**STEP 3:** Click the *Accounts* tab at the top, and then choose *Account Summary* to confirm that your annual election(s) are accurate. If there are any discrepancies in your account information, please contact us at (800) 445-7227 ext. 1883.

<b>SUBMIT YOUR CLAIMS:</b>	<b>CONTACT US:</b>
<p><b><i>For fastest processing, upload your claims online. You may also fax claims and receipts to: (866) 635-1329</i></b></p> <p>Mail claims and receipts to: Gilsbar, LLC Attn: Flex PO Box 965 Covington, LA 70434</p> <p><i>(Please keep the original documents for your records.)</i></p>	<p><b><i>Customer Contact Center</i></b></p> <p><b><i>Phone: (800) 445-7227 ext. 1883 Email: <a href="mailto:flex@gilsbar.com">flex@gilsbar.com</a></i></b></p> <p><b><i>7:00 a.m. – 7:00 p.m. CST</i></b></p>



# Your Healthcare FSA

## WHAT IS A HEALTHCARE FSA?

Provided by your employer, a Healthcare FSA is a reimbursement account that allows you to set aside a certain amount of money each paycheck, pre-tax, to help pay for out-of-pocket medical expenses for you and your family. The amount you elect is deducted from gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified medical expenses, you can save an additional 20-30% on your healthcare expenses.

## HOW DOES THE HEALTHCARE FSA WORK?

With an FSA, you must decide on your contribution amount at the beginning of the plan year. The amount you designate will be equally deducted from your pay each pay period. To estimate the out-of-pocket expenses that you, your spouse, and your dependents may incur, consider any standard co-pays, prescriptions, office visits, and planned medical expenses, i.e. braces or LASIK eye surgery. Please use the provided expense worksheet to help you determine the amount of money to allocate for your Healthcare FSA.

The IRS requires that all money in the account be used during the plan year. Money cannot be returned to you or carry over to the following year. For this reason, it is better to underestimate your expenses at the beginning of the plan year when you decide your election amount. To help avoid this situation, you will receive a notice of your balance prior to the end of the plan year, so you can use that balance on qualified expenses prior to the last day of the current plan year.

## HOW EASY IS IT TO MANAGE MY HEALTHCARE FSA?

Very easy! Visit [myGilsbar.com](http://myGilsbar.com) and log in 24/7 to access claims information and FSA balances online. Once you are logged in, select the "FSA and HRA" link to view your personalized FSA homepage. If you are new to myGilsbar, complete the brief site registration to log in. You will need your group number (found on your ID card), Social Security number, and a valid e-mail address to complete this section. As a registered user, you can:

- Review Action Alerts to keep current on your accounts.
- File a claim online and upload receipts and other documentation
- View account balances and history
- View payments and next payment dates
- Report lost or stolen debit cards
- Review instructions to download Gilsbar's FSA mobile app

## HOW DOES THE FSA SAVE ME MONEY?

The following example illustrates the per pay period savings for an employee on a bi-monthly payroll with a tax status of "single" with one exemption:

	With FSA	Without FSA
<b>Salary:</b>	\$1000.00	\$1000.00
<b>Less Pre-Taxed Dollars:</b>		
Healthcare Reimbursement	-\$100.00	\$0.00
<b>Taxable Income</b>	<b>\$900.00</b>	<b>\$1000.00</b>
<b>Less:</b>		
Federal Income Tax (15%*)	-\$135.00	-\$150.00
State Income Tax (5%*)	-\$45.00	-\$50.00
Social Security (7.65%*)	-\$68.85	-\$76.50
<b>Net Take Home Pay:</b>	<b>\$651.15</b>	<b>\$723.50</b>
<b>Less Healthcare Expenses</b>	<b>-\$0.00</b>	<b>-\$100.00</b>
<b>Net After Expenses:</b>	<b>\$651.15</b>	<b>\$623.50</b>

\*Your income tax rates will vary based on your income and the state in which you reside\*

## CAN I CHANGE MY CONTRIBUTION AMOUNT?

Generally, you may not change your FSA election during the plan year. However, you may make changes during the annual enrollment period for the coming plan year. There is one exception to this rule: you may change your contribution amount during the plan year if you have a qualifying change in family status that affects benefit eligibility during the plan year. Examples include:

- Change in legal marital status
- Change in number of tax dependents
- Termination or commencement of employment
- Dependent satisfies or ceases to satisfy dependent eligibility requirements, judgment decree, or order

## MOST COMMON ELIGIBLE EXPENSES

- Dental Services
- Orthodontia/Braces
- Co-pay Amounts
- Deductibles
- Lab Exams/Tests
- Insulin
- Nicotine Gum or Patches
- Prescription Drugs
- Hospital Services
- Physical Therapy
- Well Baby Care
- Contact Lenses
- Contact Lens Solution
- Eye Examinations
- Eyeglasses
- Laser Eye Surgeries

## HEALTHCARE FSA EXPENSE WORKSHEET

The below worksheet has been prepared to help you determine the amount of money you wish to allocate to your Healthcare FSA. You may want to review your checkbook register or credit card statements from last year to identify medical expenses you paid out of your own pocket. Using this information and the worksheet, you can estimate the amount you wish to allocate, on a pre-tax basis, to your Healthcare FSA (keeping in mind to only budget for those expenses specifically eligible under your Healthcare FSA).

HEALTHCARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:	
<b>Deductibles</b> (medical and dental) Benefit percentage/co-insurance (The amount NOT paid by your insurance)	\$ _____ \$ _____
<b>Amounts</b> paid over plan limits Over reasonable and customary allowance Over psychiatric limits Over private room allowance	\$ _____ \$ _____ \$ _____
<b>Expenses</b> NOT covered by your insurance plan Physicals Prescription Drugs Vision Care Hearing Expenses Psychiatric Care Dental and Orthodontic Care Assistance for the Handicapped Therapy / Treatments Physician's Fees / Services Medical Equipment Miscellaneous Charges  <b>My out-of-pocket healthcare expenses last year</b>	\$ _____ \$ _____  TOTAL \$ _____
Compare last year's typical expenses to those eligible under your Healthcare FSA and budget accordingly for the upcoming year.	





## FSA Debit Card

what you need to know

### HOW DOES THE FSA DEBIT CARD WORK?

Shortly after enrolling in a Healthcare Flexible Spending Account (FSA), you will receive your FSA Debit Card to use for your eligible medical expenses. If you are a current participant, your card will reflect the new plan year contribution amount on the new effective date of the plan. As you incur expenses, use your FSA Debit Card to have the funds taken directly out of your account so you don't have to pay with cash out of your pocket.

### IF I USE MY FSA DEBIT CARD, IS VERIFICATION OF CLAIMS STILL REQUIRED?

Per IRS requirements, verification of claims is required for all debit card transactions. A large portion of debit card transactions can be verified using one of the IRS's approved electronic methods; however, not all transactions can be verified this way. For any expense that cannot be verified electronically you must provide supporting documentation upon request in the form of an itemized bill or receipt to Gilsbar. Verification should include the patient name, date of service, description of services rendered, cost, and patient liability. If Gilsbar does not receive verification of transactions within 30 days of the date requested, you will be asked to return the un-verified amounts to your employer, or they may be counted as taxable income to you.

### HOW CAN I PROVIDE SUPPORTING DOCUMENTATION?

If you receive a substantiation request letter please go to [www.myGilsbar.com](http://www.myGilsbar.com) to electronically upload any required receipts.

For each claim that requires a receipt, click "Upload Receipt" on the far right of the Accounts Page under your Home Page and follow the instructions. (Your receipt must be in .doc, pdf, bmp, or gif format.) Upon successful upload, the Receipt Uploaded confirmation appears: "Your receipt has been uploaded. You may upload additional receipts if needed until the claim is approved." After uploading, you may also click "View Confirmation" and print the form for your records.

NOTE: If you see a "Receipts Needed" link in the Action Required section of your Home Page, click on it. A listing of any Claims Requiring Receipts will appear.

### WHERE CAN I USE MY FSA DEBIT CARD?

Your FSA Debit Card will only be accepted at authorized vendors that have the appropriate merchant codes, such as medical clinics, hospitals, dental offices, vision care centers, and pharmacies.

### WHAT DO I NEED TO KNOW ABOUT PAYING FOR PRESCRIPTIONS?

Effective January 1, 2011, OTC medications and drugs (other than insulin) will no longer be reimbursed by an FSA unless they are accompanied by a doctor's prescription. Medications or drugs must meet one of the following criteria to be eligible for reimbursement:

- 1) The medicine or drug requires a prescription.
- 2) The medicine or drug is available without a prescription and the individual obtains a prescription.
- 3) The medicine or drug is insulin.

### CAN I USE MY FSA DEBIT CARD FOR ELIGIBLE DEPENDENT CARE EXPENSES?

No. Your FSA Debit Card may not be used to pay for eligible Dependent Care expenses. Your card will only be accepted at authorized vendors that have the appropriate merchant codes, such as medical clinics, hospitals, dental offices, vision care centers and pharmacies.

### WHAT HAPPENS IF THE FSA DEBIT CARD IS USED FOR AN INELIGIBLE EXPENSE?

Gilsbar will review all charges and determine if the card was used for an ineligible expense, according to IRS guidelines. If it was, we will notify you for repayment of the invalid amount. Failure to repay within 30 days of the request can result in the loss of your debit card privileges.

### WHAT SHOULD I DO TO PAY FOR AN EXPENSE THAT IS MORE THAN MY ACCOUNT BALANCE?

You should tell the merchant to swipe your card for the amount equal to what is left in your account, then use another payment method to pay the remaining balance.



# Your Dependent Care FSA

## WHAT IS A DEPENDENT CARE FSA?

A Dependent Care FSA is a reimbursement account that allows you to set aside a certain amount of money each paycheck on a pre-tax basis to pay for your eligible dependent day care expenses. The amount you elect at the beginning of each plan year is deducted from your gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified expenses, you can save 20-30% on dependent care expenses.

## HOW DOES THE DEPENDENT CARE FSA WORK?

With an Dependent Care FSA, you must decide on your contribution amount at the beginning of the plan year. The amount you designate will be equally deducted from your pay each pay period. To estimate your dependent care expenses, consider your expenses from last year. Please use the provided expense worksheet to help you determine the amount of money to allocate for your Dependent Care FSA. The IRS requires that all money in your account be used during the plan year. An eligible dependent is defined as any person who can be claimed as a dependent for federal tax purposes and who:

- Is a child under 13 years of age
- Is a child over the age of 13 who is physically or mentally incapable of caring for himself or herself
- Is your spouse and is physically or mentally incapable of caring for himself or herself
- An elderly parent who resides with you and is physically or mentally incapable of caring for himself or herself

## HOW EASY IS IT TO MANAGE THE DEPENDENT CARE FSA?

Very easy! Visit [myGilsbar.com](http://myGilsbar.com) and log in 24/7 to access claims information and FSA balances online. Once you are logged in, select the "FSA and HRA" link to view your personalized FSA homepage. If you are new to myGilsbar, complete the brief site registration to log in. You will need your group number (found on your ID card), Social Security number, and a valid e-mail address to complete this section. As a registered user, you can:

- Review Action Alerts to keep current on your accounts.
- File a claim online and upload receipts and other documentation
- View account balances and history
- View payments and next payment dates
- Report lost or stolen debit cards
- Review instructions to download Gilsbar's FSA mobile app

## HOW CAN A DEPENDENT CARE FSA SAVE ME MONEY?

The following example illustrates the per pay period savings for an employee on a bi-monthly payroll with a tax status of "single" with one exemption:

	With FSA	Without FSA
<b>Salary</b>	\$1000.00	\$1000.00
<b>Less Pre-Taxed Dollars</b>		
Dependent Day Care Reimbursement	-\$192.00	\$0.00
<b>Taxable Income</b>	\$808.00	\$1000.00
<b>Less:</b>		
Federal Income Tax (15%*)	-\$121.20	-\$150.00
State Income Tax (5%*)	-\$40.40	-\$50.00
Social Security (7.65%*)	-\$61.81	-\$76.50
<b>Net Take Home Pay</b>	\$584.59	\$723.50
Less Dependent Care Expenses	-\$0.00	-\$192
<b>Net After Expenses</b>	<b>\$584.59</b>	<b>\$531.50</b>

\*Your income tax rates will vary based on your income and the state in which you reside\*

## WHAT EXPENSES ARE COVERED?

Eligible dependent care expenses are those which allow you and your spouse, if you are married, to work or attend school full time. Private school tuition K4 and above is not eligible for reimbursement. Below are some examples of eligible dependent care expenses:

- Day care facility fees
- Before / after school care
- Summer day camp (not overnight)
- Nursery school or preschool, if child is too young for Kindergarten
- In home babysitting fees, if not provided by another dependent and claimed as income by the care provider



## HOW DO I GET REIMBURSED?

As you incur eligible expenses, you must complete a Dependent Care FSA claim form and attach proof of payment from your day care provider or from the individual who provides the care. The claim form and documentation of expense can be submitted online at [www.myGilsbar.com](http://www.myGilsbar.com) or by using the Gilsbar FSA Mobile App. Dependent Care FSA claims must include the federal tax identification number or Social Security number, name, and address of the provider, dates of service, type of service rendered, and name of dependent. The individual who provides the care cannot be your spouse or a dependent under the age of 19. With a Dependent Care FSA, you will be reimbursed as you set funds aside. If you submit a claim for more than what has been set aside for that account, the unreimbursed claim portion will be placed in "pending" status until funds are received through payroll deduction, at which time you will receive reimbursement.

## DEPENDENT CARE FSA EXPENSE WORKSHEET

The worksheet below has been prepared to help you determine the amount of money you wish to allocate to your Dependent Care FSA. You may want to review your checkbook register or credit card statements from last year to identify expenses you paid out of your own pocket. Using this information and the worksheet, you can estimate the amount you wish to allocate, on a pre-tax basis, to your Dependent Care FSA (keeping in mind to only budget for those expenses specifically eligible for your Dependent Care FSA).

## CAN I CHANGE MY ELECTION DURING THE PLAN YEAR?

Generally, you may not change your FSA elections during the plan year unless you have a change in family status that change benefit eligibility during the plan year. Otherwise, you may change during the annual enrollment period for the coming plan year. Examples of a qualifying status change may include:

- Marriage, divorce, or legal separation
- Birth, adoption, or placement for adoption of a child
- Death of a dependent or spouse
- Change in your or your spouse's employment status
- A significant change caused by a third party in the cost of your dependent care coverage

### DEPENDENT CARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:

#### Costs of Child or Adult Care Facilities\*

Day Care Center / Nursery School \$ \_\_\_\_\_

Family Day Care / Adult Day Care Centers\*\* \$ \_\_\_\_\_

Wages paid to a nanny or in home care provider\*\*\* \$ \_\_\_\_\_

\* The facility must follow all local and state laws.

\*\* These costs are eligible only if the adult dependent spends at least eight hours per day at your home.

\*\*\* Please note these expenses are not eligible if the care services are provided by someone that you claim as a dependent.

Other dependent care expenses considered eligible by the IRS \$ \_\_\_\_\_

**TOTAL ESTIMATED DEPENDENT CARE EXPENSES** \$ \_\_\_\_\_

Compare last year's typical expenses to those eligible under your Dependent Care FSA and budget accordingly for the upcoming year.



# FSA Substantiation

proof of eligible debit card purchases

## IRS REGULATIONS ON FSA DEBIT CARDS

The IRS sets regulations regarding how debit cards operate in conjunction with a Flexible Spending Account (FSA). According to these rules, there are five basic requirements that must be met for you to use an FSA debit card.

- Participants must provide certification each year that they will only use the debit card for FSA eligible items. This is done during the enrollment process.
- The participant must retain all receipts for all transactions.
- 100% of debit card transactions must be reviewed by a third party to ensure that the items purchased are FSA eligible.
- Sampling or employee “self-certification” is not allowed.
- Debit cards can only be used at locations that are medical service providers or provide point of purchase review.

Fortunately, the IRS defines several Auto-Substantiation (electronic substantiation) methods that we can use to help with the adjudication process.

These methods are:

- **Co-pay Match** – If a transaction equals a co-pay amount or multiples of co-pay amounts under the health plan, no additional information is needed to support a card transaction.
- **Recurring Expense** – For transactions that were previously substantiated, recurring expenses will also be considered substantiated provided they are incurred with the same provider at the same location for exactly the same amount.
- **Real-Time or Merchant Substantiation** – If a transaction can be matched against real-time data at the point of purchase identifying it as a medical expense, no additional substantiation is needed.

## WHY DOES THE IRS HAVE THESE RULES? ISN'T IT MY MONEY?

Yes, the money that you put into an FSA is your money; however, in order to receive this money WITHOUT paying taxes you must follow the rules that the IRS has provided for the receipt of an FSA pre-tax reimbursement. At the present time, these rules require all administrators to verify that the money in the FSA is being used for medical care purposes.

## WHAT SHOULD I DO IF I RECEIVE A SUBSTANTIATION REQUEST?

You may receive requests for Manual Substantiation in the event that the charges do not qualify for Auto-Substantiation. If you receive a substantiation request, please go to [www.myGilsbar.com](http://www.myGilsbar.com) to electronically upload any required receipts.

For each claim that requires a receipt, click “Upload Receipt” on the far right of the Accounts Page under your Home Page, and follow the instructions. (Your receipt must be in .doc, pdf, bmp, or gif format.) Upon successful upload, the Receipt Uploaded confirmation appears: “Your receipt has been uploaded. You may upload additional receipts if needed until the claim is approved.” After uploading, you may also click “View Confirmation” and print the form for your records.

NOTE: If you see a “Receipts Needed” link in the Action Required section of your Home Page, click on it. A listing of any Claims Requiring Receipts will appear.

## WHAT ARE ACCEPTABLE FORMS OF SUBSTANTIATION?

Acceptable forms of substantiation include: Explanation of Benefits (EOBs) and register/provider receipts showing the name and address of the merchant or provider, date of service, items purchased, and dollar amount charged. Credit card receipts are not an acceptable form because they are not itemized; Gilsbar cannot verify that the expense was an FSA eligible item.

## ARE PROVIDERS, PHARMACIES, HOSPITALS, ETC. REQUIRED TO PROVIDE A RECEIPT WITH SERVICE?

No, it is not a requirement that they provide a receipt, but we suggest you always ask for and collect a receipt from medical providers and facilities. If you are ever audited by the IRS, they will require these receipts for validation of purchases.

## SHOULD I KEEP COPIES OF MY RECEIPTS?

Yes, because FSAs are federally regulated accounts, we do encourage you to practice good record-keeping habits. Just like you track other items for tax purposes each year, consider your FSA documentation just as important. It is our recommendation that you keep these receipts for your personal records in addition to sending them to Gilsbar.



# FSA/HRA Employee Portal

## Quickstart Guide

Welcome to your Gilsbar Benefit Accounts Employee Portal. This one-stop portal gives you 24/7 access to view your information and manage your Flexible Spending Account (FSA) and Health Reimbursement Arrangement (HRA), if applicable. It enables you to:

- File a claim online
- Upload receipts and track expenses
- View up-to-the-minute account balances
- View your account activity, claims and payment (reimbursement) details
- Report a lost/stolen card and request a new one
- Download forms and notifications

### ACCESSING YOUR PORTAL

1. Visit [www.myGilsbar.com](http://www.myGilsbar.com)
2. **If you have an existing myGilsbar account**, log in with your user ID and password. **If you are new to myGilsbar**, complete the brief registration to log in. You will need your Gilsbar group number, Social Security number, and a valid email address to complete this section.
3. Once logged in, click the “FSAs and HRAs” link on the left navigation panel to access your information.

The screenshot displays the myGilsbar.com website interface. At the top, there is a navigation bar with links for "Your Good Health", "Forms", "Contact Us", and "Technical Support". Below this is a banner for "Protect Yourself & Your Family from Cancer" with the text "You Are What You Eat" and "Get Physical and Be F.I.T.T.". Another banner promotes "TO YOUR GOOD HEALTH Recipes to make you & your doctor smile!". The main content area shows a login form with fields for "Email/User ID" and "Password (Capitalization matters)", a "Login" button, and links for "Forgot Your User ID or Password?", "Password/Technical Assistance", and "First Time User? Click here to register.".

**GILSBAR**

HOME ACCOUNTS PROFILE NOTIFICATIONS FORMS LINKS John Black  
Login: 11/15/2013 - Online | Logout

Welcome

We're Making it Easy to Manage Your Healthcare Expenses

I Want To...

File A Claim  
Manage My Expenses

Available Balance

Dependent Care Re...	\$1,050.00
Health Reimbursm...	\$225.00
Health Care Reimb...	\$2,175.00

Message Center

Download Mobile App View More  
To get your money faster, set up a bank account for direct deposit

Quick View

Election Summary for 2013

Contributions to Date  
1/1/2013 - 12/31/2013

Your Contributions  
\$3,586.68 of \$8,000.00

Total Contributions  
\$3,586.68 of \$8,000.00

● \$5,000.00 to Dependent Care Reimbur  
 ● \$2,500.00 to Health Care Reimbursm  
 ● \$500.00 to Health Reimbursement Acc

## NAVIGATING THE HOME PAGE

The top section of the home page has a drop-down menu with useful links for managing your accounts.

Just below the **Welcome**, there are links to file a claim and to manage your expenses. Your **Available Balance** for each of your accounts will display towards the right side of the page. Click *Available Balance* to view a detailed account summary.

Your account information can also be accessed through the **Accounts** tab. Click on each account name to view that account's details. (You may need to set your browser to allow pop-ups from the site.)

The **Message Center** displays helpful information, alerts, and relevant links. If you see a *Receipts Needed* link in your **Message Center**, click on it. A listing of any claims requiring receipts will appear.

In the **Quick View** section, you will see a helpful graphical summary of paid claims, elections for the current plan year, and your contributions to date.

## HOW TO FILE A CLAIM AND UPLOAD A RECEIPT

1. On the **Home Page**, under the **Accounts** tab, click *File Claims* on the drop-down menu.
2. Enter your claim information and upload the receipt. You may also enter your mileage reimbursement information at this time. Once you have completed the form, click *Add Claim*.
3. You will be directed to your **Claims Basket**. You may choose to *Add Another Claim* or submit the claim(s) listed.
4. When all of your claims are added to the **Claims Basket**, check the box to confirm that you have read and agree to the Terms and Conditions.
5. Click *Submit* to send your claims for processing. The **Claim Confirmation** page will display. You may print the Claim Confirmation Form as a record of your submission.



## FSA/HRA Mobile App

manage your accounts on-the-go

Gilsbar is pleased to announce the release of our FSA & HRA mobile application for your iPhone, Android, and tablet devices.

With the mobile app, you can:

- Check your FSA and HRA account balances
- View account activity and receive alerts via text message
- File new claims with receipt images
- Enter a new expense and review expense information
- Upload receipts using your mobile device's camera
- Manage expense receipts



### DOWNLOADING THE APP

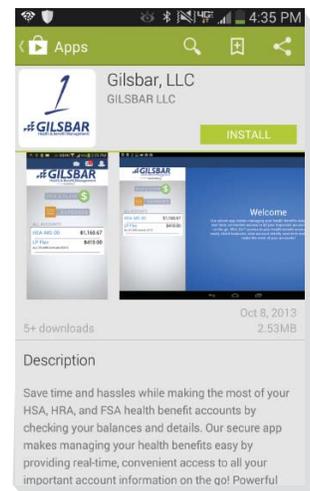


#### For Apple Devices:

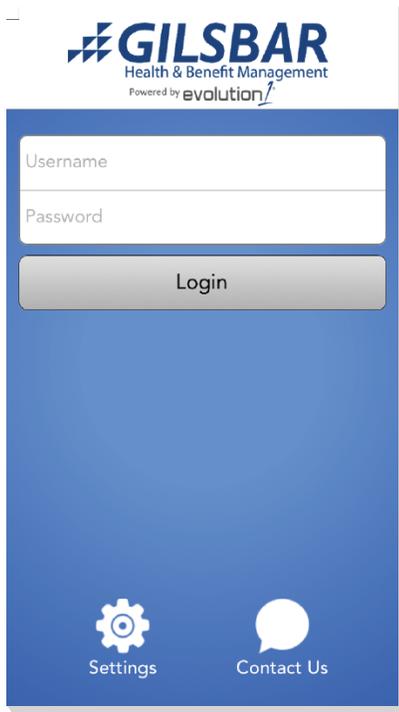
- Open the App store and search for “Gilsbar FSA HRA.”
- Tap “Free” and then “Install.” You will be prompted for your apple ID log in information. Enter it and select “OK.”
- Once the app is downloaded, tap its icon to open it on your device.

#### For Android Devices:

- Open the Google Play Store or Market and search for “Gilsbar FSA HRA.”
- Tap the Gilsbar app icon.
- Tap “Install” and then “OK.”
- Once the app is downloaded, tap its icon in your app lists to open it on your device.



## LOGGING IN TO THE MOBILE APP



- Before you log in for the first time, you will need your participant ID number.

Your participant ID can be found in the FSA/HRA section of myGilsbar.com by clicking the arrow to the right of your name.



- Tap the Gilsbar icon to launch the app. You will be prompted to enter your username (participant ID) and password (Welcome1).
- After you enter the password, you will be prompted to set and confirm a 4-digit PIN. Each subsequent log in will require only your PIN.

If you would like assistance installing or logging in to the mobile app, please contact our Customer Contact Center!  
1-800-445-7227, ext 1883 • flex@gilsbar.com

## INSIDE THE MOBILE APP

Once you're logged in to the app, you're seconds away from managing your FSA & HRA accounts from your phone.

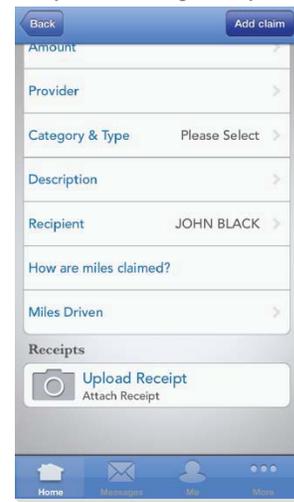
view account balances & activity



file new claims



upload & manage receipts



# *Ameritas Dental Plan - PPO & Non-PPO Options*

**Effective Date: July 1, 2014**

## **PPO vs. Non-PPO**

The coinsurance levels for dental procedures are the same for both the PPO and Non-PPO plan. The main differences are the allowance for each procedure and the deductible being waived for all procedures when a participating provider is visited.

Under the PPO plan, the procedure allowance is based on the Maximum Allowable Charge (MAC). This means if you go to a PPO provider, you will pay the coinsurance based on the discounted fee Ameritas has negotiated with that provider. However, if you go to a provider that is not in the network, Ameritas will only reimburse the Maximum Allowable Charge (MAC) and you will be responsible for the difference in cost. Therefore, you are highly encouraged to use an in-network provider to benefit from the plan.

Under the Non-PPO plan, you can see any provider. However, if you visit an out-of-network provider, the provider can charge their standard fee and Ameritas will reimburse based on the 90th percentile of Usual & Customary charges (U&C). This means 9 out of 10 dentist's charges fall within the amount Ameritas allows for each procedure.

With each plan type, you'll want to note that the deductible is \$0 for all PPO services (rather than \$50 for Type 2 & 3). Also, there is a 12 month waiting period on Type 3 (Major) services.

## **Combined Calendar Year Deductible**

\$50.00 per individual for Type 2 - Basic Procedures and Type 3 - Major Procedures (3 times family limit). After the date that 3 covered family members have each satisfied their individual deductible the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

## **Type 1 - Preventive and Diagnostic**

**PPO** - Type 1 benefits are payable at 100% MAC. **No deductible applies.**

**Non-PPO** - Type 1 benefits are payable at 100% U&C. **No deductible applies.**

- Evaluations (Two per calendar year)
- Cleanings (Two per calendar year)
- Fluoride for Children (Once a year)  
(Under age 19)
- Sealants (under 17)
- Space Maintainers
- Radiographs (X-rays)
- Bitewings x-rays  
(Two per calendar year)

### **Type 2 - Basic Procedures**

**PPO** - Type 2 benefits are payable at 50% MAC \$50.00 deductible applies.

**Non-PPO** - Type 2 benefits are payable at 50% U&C. \$50.00 deductible applies.

- Oral Surgery
- Restorative Amalgam & Resin
- Re-cement/Repair- Crowns
- Anesthesia
- Denture Repair

### **Type 3 - Major Procedures**

**PPO** - Type 3 benefits are payable at 50% MAC. \$50.00 deductible applies.

**Non-PPO** - Type 3 benefits are payable at 50% U&C. \$50.00 deductible applies.

- Restorative - Crowns
- Prosthodontics- (Removable Dentures, Partial)
- Endodontics (Root Canal)
- Periodontics (Gum Disease)
- Prosthodontics - Fixed Pontics or Abutment
- Crown Repair

### **Orthodontia - Children only - 12 month waiting period**

• Paid at 50% U&C\* with a \$1,000 lifetime maximum per person. **No deductible applies.**

Benefits will be payable when a Covered Expense is incurred. The Covered Expenses for a program are based on the estimated cost of the insured's program. They are pro-rated by quarter (three month periods) over the estimated length of the program, but not for more than eight quarters. The last quarterly payment for a program may be changed if the estimated and actual cost of the program differ.

### **Annual Maximum Benefit**

- Type 1, 2, and 3 Procedures - \$1,500 per calendar year per person.
- Orthodontia Procedures - \$1,000 Lifetime per person (carryover does not apply)

### **Eligible Employees**

You are eligible for insurance if you are a part-time active employee working at least 20 hours per week.

### **Eligible Dependents**

Provides Coverage On:

- Your Spouse
- Children up to age 19 and unmarried (Up to age 25 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college.)

### **Pre-Determination of Benefits**

A treatment plan MAY be filed if a proposed course of treatment will exceed \$200.00. With this information, Ameritas can determine the benefits payable under this policy prior to the work actually being done. It will give the insured the amount payable, along with an idea of the out of pocket expense.

### **Coordination of Benefits**

If you or any of your dependents incur charges which are covered by any other group plan, the benefits of this plan will be coordinated with the benefits of the other plan so that the total benefits received are not greater than the charges incurred.

### **Late Entrant Provision**

There is a 12 month waiting period on all procedures (except cleanings, exams, and fluoride treatments) for employees who do not enroll within 31 days of becoming eligible for coverage. This provision is waived for employees who enrolled during the initial enrollment period.

### **Certificate of Insurance**

This is a summary of coverage and is not a binding contract. A certificate of coverage will be made available to you shortly which describes the benefits in greater detail. Should there be differences between this summary and the contract, the contract will govern.

### **Section 125**

This policy is provided as part of the Policyholder's Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy.

### **Orthodontia Limitations (not a complete list)**

No benefit is payable for expenses incurred:

- In connection with a Treatment Program which was begun before the individual became insured for orthodontic benefits.
- During any quarter of a Treatment Program if the individual was not continuously insured for orthodontic benefits for the entire quarter.
- After the individual's insurance for orthodontic benefits terminates.

### **Limitations/Exclusions (not a complete list)**

- For any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the 2nd bicuspid are considered cosmetic.
- Charges incurred prior to the date the individual became insured under this plan, or following the date of termination of coverage.
- Services which are not recommended by a dentist or which are not required for necessary care and treatment.
- Expenses incurred to replace lost or stolen appliances.
- Expenses incurred by an insured because of a sickness for which he/she is eligible of benefits under Worker's Compensation Act or similar.

**A member may change their election only during an annual election period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.**

This information is not a guarantee of eligibility or benefits. The benefits shown are subject to policy provisions and the patient's eligibility at the time services are rendered.

<b>Monthly Rates</b>		
	<b>PPO Plan*</b>	<b>Non-PPO Plan</b>
<b>Employee Only</b>	<b>\$21.88</b>	<b>\$25.24</b>
<b>Employee &amp; Spouse</b>	<b>\$41.56</b>	<b>\$47.96</b>
<b>Employee &amp; Children</b>	<b>\$52.64</b>	<b>\$60.72</b>
<b>Family</b>	<b>\$71.76</b>	<b>\$82.80</b>

\*To access the full value of the PPO Plan, you are strongly encouraged to utilize In-Network providers. If you are not planning to utilize an In-Network Provider, do not enroll in the PPO Plan or your Out-of-Network benefits will be significantly reduced. Out-of-Network benefits will be paid based on the maximum allowable charge.

**Customer Service**

1-800-487-5553

**Web Address**

[www.ameritasgroup.com](http://www.ameritasgroup.com)



This insurance is underwritten by Ameritas Life Insurance Corp.

# *Ameritas PPO Dental FAQ*

## **Commonly Asked PPO Questions**

Duplin County Government wants employees to have options regarding their dental benefits. You have a choice of enrolling in the PPO plan or the Non-PPO plan. Both plans are administered by Ameritas and the benefits in each plan are very similar. The key difference in the PPO and Non-PPO option is the decision of utilizing one of the many participating network providers or choosing to use a non-network provider when seeking dental services. Utilizing a network provider will allow greater cost savings opportunities in terms of your premium dollars as well as out of pocket costs.

## **Do I have to use an Ameritas PPO provider?**

No, you and your covered dependents can choose to visit any licensed dental provider. However, if you choose to enroll in the PPO option – having lower premium rates – you are strongly encouraged to utilize a participating network provider in order to realize the true benefits of the plan including lower out of pocket costs. While the benefits of the PPO and Non-PPO plans are very similar, the reimbursement allowances are different between the two options.

## **Why would I use an Ameritas PPO provider?**

A Participating Provider is a dentist who has entered into an agreement to provide services to insured members of Ameritas' plans for at a specific fee. Any insured member who chooses to go to a PPO provider will receive this discounted fee for procedures performed by that provider. As part of their contractual agreement with Ameritas, the PPO provider cannot "back-bill" the patient for the difference between the dentists' normal charges and the discounted fees that the dentist agreed to charge as an Ameritas PPO provider. PPO providers are required to file the claim for the patient.

PPO providers are required to wait for reimbursement from Ameritas before billing the patient for any balances owed for deductibles, coinsurance, any amounts exceeding the annual maximum benefits, etc. PPO panels are available in many areas; please visit the Ameritas website at [www.ameritasgroup.com](http://www.ameritasgroup.com) to search for a provider in your area.

## **What happens if I don't use an Ameritas PPO provider?**

As mentioned above, you have a choice of enrolling in the PPO or the Non-PPO plan.

Members enrolling in the PPO plan should utilize a participating provider for all procedures and services in order to benefit from the plan and the Maximum Allowable Charge (MAC) reimbursement tied to the PPO option.

Members enrolling in the Non-PPO plan can visit any dental provider. Non-panel providers can charge their standard fees and Ameritas will reimburse based on the 90th percentile of U&C – which is considered to be one of the highest reimbursement levels in the industry. This means that 9 out of 10 dentist's charges

will fall within the amount that Ameritas allows for each procedure. In doing so, employees can feel comfortable that very little back billing will occur due to the amounts allowed by the plan.

Non-panel providers have no specific requirements regarding filing of claims. However, many dentists will assist the patient with the paperwork needed to file the claim. If a dentist is not willing to file the claim on the patient's behalf, the patient can simply attach the dentist's bill to a claim form that includes the patient's name and identification number, and fax or mail the claim to Ameritas for processing. Ameritas will process the claim, typically within 7-10 working days. Claim payment can be made to the patient or directly to the dentist if noted on the claim form. The patient can use Ameritas' claim forms which are available in the Benefit's Department or on Ameritas web site (this will be available via our Intranet in the near future), OR the patient can use any generic claim forms that the dental office may have available. Filing claims is fast and easy with Ameritas!

If you have any questions about PPO or the plan, please call:  
Ameritas Group Claims Department at 800-487-5553

Or, visit the Ameritas website at:  
[www.AmeritasGroup.com](http://www.AmeritasGroup.com)

This insurance is underwritten by Ameritas Life Insurance Corp.

**Customer Service**

1-800-487-5553

**Web Address**

[www.ameritasgroup.com](http://www.ameritasgroup.com)



# *Community Eye Care Vision Plan*

**Effective Date: July 1, 2014**

The County's vision benefit has been enhanced through the addition of a voluntary (optional) eyewear plan. The new eyewear plan, which is administered by Community Eye Care, enables employees and their family members to significantly reduce their expenditures for glasses and contact lenses.

**Eyewear Plan: \$130 Annual Allowance for Eyewear (\$10 co-pay)**

**Frequency: 12 Months**

**The eyewear allowance is completely flexible. Members can apply their allowance to any of the following items:**

Frames	UV protection
Single-vision lenses	High-index lenses
Standard bifocal lenses	Photochromic lenses (transitions)
No-line bifocals	Scratch-resistant coating
Trifocals	Anti-reflective coating
Progressive lenses	Tints
Disposable contact lenses	Oversize lenses
Gas-permeable contact lenses	Polaroid lenses
Toric contact lenses	Faceted lenses
Contact lens solutions	Polished beveled lenses
Prescription sunglasses	Slab-off lenses
Polycarbonate (shatterproof lenses)	Prisms

So long as you select eyewear having a retail price that's less than or equal to the allowance, you incur no out-of-pocket expense at the time of service, other than the applicable co-payment. If the selected eyewear has a retail price that exceeds the allowance, you are responsible only for the balance (i.e., retail minus \$130), plus the co-pay. In addition, for the purchase of glasses (frames and/or lenses), members who exceed their allowance are eligible for a 20% discount on the balance. For the purchase of contact lenses, members who exceed their allowance are eligible for a 10% discount on the balance.

Premiums for the optional Eyewear Plan are handled through payroll deduction.

## **IN-NETWORK PROVIDERS**

You may access your benefit either in-network or out-of-network. By using an in-network provider, you do not need to submit any claims; in-network providers will submit claims on your behalf. Your only payment to an in-network provider is your co-pay, plus any amount that exceeds your eyewear allowance.

## **OUT-OF-NETWORK PROVIDERS**

Members who obtain eyewear from a non-credentialed provider still receive their full benefit. Such encounters are not treated as “out-of-network” in the traditional sense. The member simply submits a claim to Community Eye Care and is reimbursed for the full amount of their eyewear allowance (minus the co-pay).

## **LASIK SURGERY**

15% discount when performed by a participating refractive surgery provider.

## **HOW TO USE THE BENEFIT**

1. Select a provider from the Community Eye Care provider network.
2. Call the provider to make an appointment, and let them know that you have Community Eye Care coverage.
3. See the doctor and select your eyewear.
4. Your only payment to the provider is your co-pay, plus any amount that exceeds the \$130 eyewear allowance.

## **EXCLUSIONS & LIMITATIONS**

- The Community Eye Care vision plan applies solely to the purchase of eyewear. The following are not covered under the plan: a) medical eye care, b) surgical eye care, c) low vision services, d) emergency eye care
- Benefits may not be carried forward to a subsequent benefit period.
- Coordination of benefits is not permitted.
- Family coverage includes the employee, spouse, and any children or persons who are listed as dependents for income tax purposes.
- Vision benefit coverage will remain in effect for a minimum of twelve (12) months (or, with respect to new employees who enroll mid-year, until the next renewal date). Covered members aren't permitted to terminate coverage prior to the next open enrollment period unless: a) the employee is terminated from employment, or b) the employee has undergone a qualifying event. At the time of open enrollment, vision coverage will automatically renew unless voluntarily terminated by the employee.
- Additions or deletions of members which are not received by the first day of a given month will be effective as of the first day of the following month. Pro-rating of benefit rates for a partial month's coverage is not permitted.
- Notice of termination will need to be received within thirty (30) days of an employee's termination date to obtain a credit. Community Eye Care will only be obligated to provide a credit for previously terminated employees dating back sixty (60) days.
- CEC vision plan members whose employment with Duplin County Government becomes terminated will be given the option of continuing their vision coverage at the same rates that applied prior to termination of employment. The administration of continued coverage will be entirely the responsibility of CEC. Duplin County Government will retain no administrative or financial obligations whatsoever with respect to CEC vision enrollees who are no longer employed by the County.

## **TERMINATION OF EMPLOYMENT**

If you leave employment with the County, you will be able to keep your voluntary eyewear plan with no increase in costs.

<b>Monthly Rates</b>	
<b>Employee Only</b>	<b>\$5.96</b>
<b>Employee + One</b>	<b>\$11.70</b>
<b>Employee + Family</b>	<b>\$18.53</b>

**Member Services, Provider Services, and Claims Services:**

**1.888-254-4290**

**FAX: 704-426-6044**

**Website: [www.communityeyecare.net](http://www.communityeyecare.net)**

**Community Eye Care  
2359 Perimeter Pointe Parkway  
Suite 150  
Charlotte, NC 28208**



# *Aflac Accident Insurance*

The Aflac coverage described in this booklet is subject to plan limitations, exclusions, definitions, and provisions. For detailed information, please see the plan brochure, as this booklet is intended to provide a **general summary** of the coverage. This overview is subject to the terms, conditions, and limitations of policy series CAI7700.

## ***What is Aflac accident insurance? Why should I consider it?***

Aflac accident insurance provides benefits for the treatment of injuries suffered as the result of a covered accident. These benefits are payable regardless of any other insurance you may have.

Many families don't budget for out-of-pocket costs associated with accidents. While we all hope to steer clear of accidents, at some point most of us will probably take a trip to the local emergency room. When you (or a covered family member) are injured in an accident, the last things on your mind are the charges that may be accumulating for services like the following:

- Ambulance ride
- Casts
- Emergency room use
- Wheelchairs
- Surgery and Anesthesia
- Crutches
- Stitches
- Bandages

These costs add up- fast. While major medical insurance can help with the cost of treatment, **what about the out-of-pocket expenses that pile up** while you or a loved one is out of work as a result of a covered accident? Aflac accident insurance **benefits are paid directly to you (unless otherwise assigned) to use as you see fit.** You can use the benefits to help with mortgage or rent payments, groceries, car payments- however you like.

## ***What are some of the highlights of the Aflac accident plan?***

- No limit on the number of claims you can file.
- An annual Wellness Benefit is included.
- Benefits available for spouse and/or dependent children.
- Provides 24-hour protection (on and off-the-job)
- Benefits for both inpatient and outpatient treatment of covered accidents.
- Guaranteed Issue (which means you may qualify for coverage without having to answer health questions).
- Payroll Deduction - Premiums are paid by convenient payroll deduction.
- Coverage will be effective the date you sign the enrollment form.
- Your plan is portable (with certain stipulations). That means you may be able to take your coverage with you if you leave your job.

***Underwritten by Continental American Insurance Company***

A proud member of the Aflac family of insurers

### ***What is guaranteed-issue coverage?***

Guaranteed-issue refers to certain types of coverage that may be issued without your having to answer health questions. Guaranteed-issue coverage is offered during your employer's initial enrollment period (and for new hires after the enrollment period).

### ***Am I eligible for Aflac accident coverage? What about my family?***

You are eligible to apply for Aflac accident coverage if you:

- Are between the ages of 18 and 69;
- Are a full-time, benefit-eligible employee;
- Are working at least **20** hours per week;
- Are not a seasonal or temporary employee.

Your spouse must be between the ages of 18 and 64 to be eligible for coverage, and dependent children must be younger than age 26.

### ***What core benefits does Aflac accident plan feature?***

#### **• Accident Benefits**

You may receive benefits if you incur one of the following covered events:

- o Fractures
- o Dislocations
- o Paralysis
- o Lacerations
- o Injuries requiring surgery
  - Eye injuries
  - Removal of foreign body
  - Ruptured disc
  - Torn knee cartilage
  - Tendons/ligaments
- o Burns (second- and third-degree)
- o Concussion
- o Coma
- o Internal injuries
- o Exploratory surgery
- o Emergency dental work

#### **• Medical Fees Benefit**

You may receive this benefit for up to six treatments per covered accident for physician charges, emergency room services and supplies, and X-rays.

#### **• Accident Follow-Up Treatment Benefit**

You may receive this benefit for up to six treatments per covered accident for follow-up treatment.

#### **• Physical Therapy Benefit**

You may receive this benefit for up to six treatments per covered accident for physical therapy.

#### **• Ambulance Benefit**

You may receive this benefit if you require transportation to a hospital by a professional ambulance service within 90 days after a covered accident.

#### **• Transportation Benefit**

You may receive this benefit if your doctor recommends hospital treatment or diagnostic study as a result of a covered accident (and the treatment/study isn't available in your hometown).

#### **• Blood/Plasma Benefit**

You may receive this benefit if you receive blood and plasma within 90 days of a covered accident.

- **Prosthesis Benefit**

You may receive this benefit if a covered accident requires the use of a prosthetic device (hearing aids, wigs, or dental aids-including (but not limited to) false teeth-are not covered).

- **Appliance Benefit**

You may receive this benefit for use of medical appliance due to injuries received in a covered accident (payable for crutches, wheelchairs, leg braces, back braces, and walkers).

- **Family Lodging Benefit**

If you are required to travel more than 100 miles for inpatient treatment of injuries suffered in a covered accident, you may receive this benefit for an immediate family member's lodging (payable up to 30 days per accident while the insured is confined to the hospital).

- **Wellness Benefit**

You may receive this benefit for one routine examination or other preventive testing once each 12-month period (payable for one covered person annually). Benefits are payable for the following:

- o Annual physical exams
- o Mammograms
- o Pap smears
- o Eye examinations
- o Immunizations
- o Flexible sigmoidoscopies
- o PSAs
- o Ultrasounds
- o Blood screenings

- **Hospital Admission Benefit**

You may receive this benefit if you are admitted to a hospital and confined as a resident bed patient because of injuries received in a covered accident within six months of the accident.

- **Hospital Confinement Benefit (per day)**

You may receive this benefit on the first day of hospital confinement for up to 365 days. The confinement must begin within 90 days after the date of the accident (payable once per confinement).

- **Hospital Intensive Care (per day)**

You may receive this benefit up to 30 days per covered accident (payable in addition to the Hospital Confinement Benefit).

- **Accidental-Death and -Dismemberment Benefit**

- o Accidental Death
- o Accidental Common Carrier Death (common carrier refers to an airline carrier, railroad train, or ship that is licensed for passenger service)
- o Dismemberment
- o Loss of One or More Fingers and Toes
- o Partial Amputation of Fingers or Toes

## What else do I need to know about the Aflac accident plan?

You should know that the plan includes:

- A **pre-existing condition limitation.** A *pre-existing condition* is a sickness or physical condition that, within the 12 month period before your plan's effective date, resulted in the insured's receiving medical advice or treatment. No benefits are payable for any condition or illness starting within 12 months of an insured's effective date that is caused by, contributed to, or resulting from a pre-existing condition.
- **Certain Exclusions.** No benefits are payable for loss resulting from:
  - Participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. This exclusion does not include acts of terrorism. We will return the prorated premium for any period not covered when you are in such service.
  - Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.
  - Participating or attempting to participate in an illegal activity or working at an illegal job.
  - Committing or attempting to commit suicide, while sane or insane.
  - Injuring or attempting to injure yourself intentionally.
  - Having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.
  - Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, The Bahamas, Virgin Islands, Bermuda and Jamaica except under the Accidental Common Carrier Death Benefit.
  - Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
  - Participating in any organized sport, professional or semi-professional.
  - Being legally intoxicated or under the influence of any narcotic unless taken under the direction of a physician.
  - Mountaineering using ropes and/or other equipment, parachuting or hang-gliding.
  - Having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of covered accident.

## Monthly Premium Rates

Employee	\$16.20
Employee and Spouse	\$23.16
Employee and Dependent Children	\$30.90
Employee, Spouse, and Dependent Child(ren)	\$37.86



Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands.

**Continental American Insurance Company • 2801 Devine Street • Columbia, South Carolina 29205 • 1-800-433-3036 toll-free • 1-866-849-2970 fax • [www.aflacgroupinsurance.com](http://www.aflacgroupinsurance.com)**

# *Allstate Benefits Group Cancer Plan*

*In the United States, about 1,596,670 new cancer cases were expected to be diagnosed in 2011. <sup>1</sup>*

## **Group Voluntary Cancer**

If you suddenly become diagnosed with cancer, it can be difficult on your family's financial and emotional stability. Having the right coverage to help when you are sick and undergoing treatment or when you cannot work is important. Our cancer insurance can help provide security when you need it most.

## **Meeting Your Needs:**

Allstate Benefits cancer coverage can help offer you and your family members financial support during a period of unexpected illness.

- Benefits will be paid directly to you unless otherwise assigned
- Coverage can be purchased for you and your entire family
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts\*
- Includes coverage for 29 other specified diseases\*\*
- Portable coverage

## **Benefit Coverage Highlights**

Group Voluntary Cancer Insurance offers you coverage should you be diagnosed with cancer or 29 specified diseases. It can help protect you and your family 24 hours a day, seven days a week.

Each pre-packaged plan doesn't just cover you; if you choose, it also covers your dependents (which can include spouse, domestic partner and children). Our valuable coverage can help supplement your traditional medical insurance which may only cover a small portion of the non-medical expenses that can be incurred with such a diagnosis as cancer.

You and each covered family member can be sure they will receive:

- Benefits that can be used to help pay for treatment, hospital stays, transportation, and more!
- Easy enrollment without required evidence of insurability †

A cancer diagnosis can mean unforeseen expenses that may be difficult to pay. Hospital stays, medical or surgical treatments, and transportation by air or ground ambulance can add up quickly and be very costly. Our Group Voluntary Cancer Supplemental Insurance can help offset some of the expenses your health insurance may not cover, so you can focus on getting well.

*\*Primary insured only*

*\*\*List of covered diseases on the following page*

*<sup>1</sup> Cancer Facts & Figures, American Cancer Society, 2011*

**In the U.S., men have slightly less than a 1 in 2 lifetime risk of developing cancer, for women, the risk is a little more than 1 in 3.<sup>2</sup>**

### ***Your Benefit Coverage***

Benefits are paid for cancer and specified diseases and can help cover the costs of specific treatments and expenses as they happen. Terms and conditions for each benefit will vary.

### ***Specified Diseases***

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis (bacterial), Brucellosis, Sickle Cell Anemia, Thalassemia, Rocky Mountain Spotted Fever, Legionnaires' Disease (confirmation by culture or sputum), Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or Chronic C with liver failure or Hepatoma), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Liver Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis and Primary Biliary Cirrhosis.

### ***Continuous Hospital Confinement***

**A \$100 benefit will be paid** for each day of continuous hospital confinement for the treatment of cancer or specified diseases.

### ***Government or Charity Hospital***

**A \$100 benefit will be paid** for each day a covered person is confined to:

- (1) a hospital operated by or for the U.S. Government (including the Veteran's Administration);
- (2) a hospital that does not charge for the services it provides (charity).

This benefit is paid in lieu of all other benefits in the policy (except Waiver of Premium Benefit).

### ***Surgery***

**Up to a \$3,000\*\* benefit will be paid** when a covered surgery (\*\*amount per surgery depends on surgery) is performed on a covered person. This benefit pays the actual charges, up to the amount listed in the Schedule of Surgical Procedures for the specific procedure. Two or more procedures performed at the same time through one incision or entry point are considered one operation; Allstate Benefits pays the amount for the procedure with the greatest benefit. Allstate Benefits pays for a covered surgery performed on an outpatient basis at 150% of the scheduled benefit. This benefit does not pay for surgeries covered by other benefits in the Schedule of Benefits.

### ***Second Opinion***

**A \$400 benefit will be paid** for a second opinion, if physician recommends surgery or treatment for covered condition. This second opinion must be rendered prior to surgery or treatment being performed, and obtained from a physician not in practice with the physician rendering the original recommendation.

**2 Cancer Facts & Figures, American Cancer Society, 2011.**

***Physical or Speech Therapy***

**A \$50 benefit will be paid** per day for physical or speech therapy for restoration of normal body function.

***Anesthesia***

**25% of the surgery benefit will be paid** for anesthesia.

***Ambulatory Surgical Center***

**A \$500 benefit will be paid** for a surgical procedure covered under the surgery benefit that is performed at an ambulatory surgical center.

***Radiation/Chemotherapy for Cancer***

**Up to a \$10,000 (Low and Mid) or \$20,000 (High) benefit will be paid** per 12-month period for radiation therapy and chemotherapy received by a covered person. This benefit pays the actual cost and is limited to the amount shown per 12-month period beginning with the first day of benefit under this provision. Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12-month period.

***Anti-Nausea Benefit***

**Up to a \$200 benefit will be paid** per calendar year for the actual cost of anti-nausea medication prescribed for a covered person by a physician in conjunction with cancer or specified disease treatment. This benefit does not pay for medication administered while the covered person is an inpatient.

***Inpatient Drugs and Medicine***

**A \$25 benefit will be paid** per day for drugs and medicine while continuously hospital confined. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy Benefit or the Anti-Nausea Benefit.

***Hematological Drugs***

**Up to a \$200 (Low and Mid) or \$400 (High) benefit will be paid** per year for the actual cost of drugs intended to boost cell lines such as white blood cell counts, red blood cell counts and platelets. This benefit is paid only when the Radiation/Chemotherapy for Cancer benefit is paid.

***Medical Imaging***

**Actual cost up to a \$500 (Low and Mid) or \$1,000 (High) benefit will be paid** per calendar year if a covered person receives an initial diagnosis or follow-up evaluation based upon one of the following medical imaging exams: CT scan, Magnetic Resonance Imaging (MRI) scan, bone scan, thyroid scan, Multiple Gated Acquisition (MUGA) scan, Positron Emission Tomography (PET) scan, transrectal ultrasound, or abdominal ultrasound. This benefit is limited to 1 payment per calendar year per covered person.

### ***Private Duty Nursing Services***

**A \$100 benefit will be paid** per day while hospital confined, if a covered person requires the full-time services of a private nurse. Full-time means at least 8 hours of attendance during a 24-hour period. These services must be required and authorized by a physician and must be provided by a nurse.

### ***New or Experimental Treatment***

**Actual charges up to a \$5,000 benefit will be paid** per 12-month period, for new or experimental treatment. New or experimental treatment is covered for cancer and specified disease when: the treatment is judged necessary by the attending physician and no other generally accepted treatment produces superior results in the opinion of the attending physician. This benefit is limited to the maximum shown per 12-month period beginning with the first day of treatment under this provision. This benefit does not pay if benefits are payable for treatment covered under any other benefit in the Schedule of Benefits.

### ***Blood, Plasma, and Platelets***

**Up to a \$10,000 (Low and Mid) or \$20,000 (High) benefit will be paid** per 12-month period for the actual cost of blood, plasma and platelets (including transfusions and administration charges), processing and procurement costs and cross-matching. Does not pay for blood replaced by donors or immunoglobulins.

### ***Physician's Attendance***

**A \$50 benefit will be paid** for a visit by a physician during hospital confinement. Benefit is limited to one visit by one physician per day of hospital confinement. Admission to the hospital as an inpatient is required.

### ***At Home Nursing***

**A \$100 benefit will be paid** per day for private nursing care and attendance by a nurse at home. At-home nursing services must be required and authorized by the attending physician. Benefit is limited to the number of days of the previous continuous hospital confinement.

### ***Prosthesis***

**Up to a \$2,000 benefit will be paid** per amputation, per covered person for the actual charges for prosthetic devices which are prescribed as a direct result of surgery and which require surgical implantation.

### ***Hair Prosthesis***

**A \$25 benefit will be paid** every 2 years for a wig or hairpiece if the covered person experiences hair loss.

### ***Nonsurgical External Breast Prosthesis***

**Up to a \$50 benefit will be paid** for the actual cost of the initial, nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy that is paid for under the policy.

### ***Ambulance***

**A \$100 benefit will be paid** per continuous hospital confinement for transportation

by a licensed ambulance service or a hospital-owned ambulance to or from a hospital in which the covered person is confined.

### ***Hospice Care***

**A \$100 benefit will be paid** for one of the following when a covered person has been diagnosed by a physician as terminally ill as a result of cancer or specified disease, is expected to live 6 months or less and the attending physician has approved services:

1. Freestanding Hospice Care Center – A benefit will be paid per day for confinement in a licensed freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or
2. Hospice Care Team – A benefit will be paid per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. Benefit is payable only if: (a) the covered person has been diagnosed as terminally ill; and (b) the attending physician has approved such services. Does not pay for: food services or meals other than dietary counseling, services related to well-baby care, services provided by volunteers, or support for the family after the death of the covered person.

### ***Extended Care Facility***

**A \$100 benefit will be paid** for each day a covered person is confined in an extended care facility for the treatment of cancer or specified disease. Confinement must be at the direction of the attending physician and must begin within 14 days after a covered hospital confinement. Benefit is limited to the number of days of the previous continuous hospital confinement.

### ***Outpatient Lodging***

**A \$50 benefit will be paid** for lodging per day when a covered person receives radiation or chemotherapy treatment on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. Benefit is the actual cost of a single room in a motel, hotel, or other accommodations acceptable to Allstate Benefits during treatment, **up to the maximum \$2,000** per 12 months beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

### ***Non-Local Transportation***

**\$0.40 per mile or actual cost of round trip coach fare on a common carrier benefit will be paid** for treatment at a hospital (inpatient or outpatient), radiation therapy center, chemotherapy or oncology clinic, or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally. Benefit pays up to 700 miles for round trip in personal vehicle. "Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. Mileage is measured from the covered person's home to the nearest treatment facility as described above. Does not cover transportation for someone to accompany or visit the person receiving treatment, visits to a physician's office or clinic, or for services other than actual treatment.

### ***Family Member Lodging and Transportation***

**Up to a \$50 benefit per day will be paid for lodging and \$0.40 per mile or the actual cost of round trip coach fare on a common carrier will be paid** for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment.

1. Lodging - This benefit is for a single room in a motel, hotel, or other accommodations acceptable to Allstate Benefits. Benefit is limited to 60 days for each period of continuous hospital confinement.
2. Transportation - Benefit is limited to 700 miles per continuous hospital confinement if traveling in personal vehicle. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. Does not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit, when the family member lives in the same city or town as the covered person.

### ***Waiver of Premium (primary insured only)***

If while coverage is in force the insured employee becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for 90 days, Allstate Benefits pays premiums due after such 90 days for as long as the insured employee remains disabled.

### ***Bone Marrow or Stem Cell Transplant\****

**A 1. \$1,000\*, 2. \$2,500\*, 3. \$5,000\* benefit will be paid** for the following types of bone marrow or stem cell transplants performed on a covered person.

1. A transplant which is other than non-autologous.
2. A transplant which is non-autologous for the treatment of cancer or specified disease, other than Leukemia.
3. A transplant which is non-autologous for the treatment of Leukemia.

**\*This benefit is payable only once per covered person per calendar year.**

## **ADDITIONAL BENEFITS**

### ***Wellness***

**A \$100 benefit will be paid** per calendar year per covered person for one of the following wellness tests: Biopsy for skin cancer; Blood test for triglycerides; Bone Marrow Testing; CA15-3 (cancer antigen 15-3 - blood test for breast cancer); CA125 (cancer antigen 125 – blood test for ovarian cancer); CEA (carcinoembryonic antigen – blood test for colon cancer); Chest X-ray; Colonoscopy; Doppler screening for carotids; Doppler screening for peripheral vascular disease; Echocardiogram; EKG (Electrocardiogram); Flexible sigmoidoscopy; Hemoccult stool analysis; HPV (Human Papillomavirus) Vaccination; Lipid panel (total cholesterol count); Mammography, including Breast Ultrasound; Cervical Cancer Screening; PSA (prostate specific antigen – blood test for prostate cancer); Serum Protein Electrophoresis (test for myeloma); Stress test on bike or treadmill; Thermography; and Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms. This benefit is paid regardless of the result of the test.

## **OPTIONAL BENEFITS**

### ***Cancer Initial Diagnosis (First Occurrence)***

**A one time benefit of \$3,000 (Low and High) or \$10,000 (Mid) benefit will be**

**paid** when a covered person is diagnosed for the first time in their life as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. Benefit is payable only once per covered person.

***Intensive Care (Low and High Plans Only)\*\****

**A benefit will be paid** for each day for the following types of intensive care confinement:

1. **Hospital Intensive Care Unit Confinement \$600\*** - This benefit is for hospital intensive care unit confinement for any illness or accident.
2. **Step-Down Hospital Intensive Care Unit Confinement \$300\*** - This benefit is for step-down hospital intensive care unit confinement for any illness or accident.
3. **Ambulance - Allstate Benefits pays the actual charges** for transportation of a covered person by licensed air or surface ambulance service to a hospital for admission to an intensive care unit for a covered confinement. This benefit is not paid if an ambulance benefit is paid under the Ambulance benefit in the policy.

***\*This benefit is limited to 45 days for each period of such confinement. A day is a 24-hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid.***

***\*\*This benefit is not disease specific and pays a benefit for covered confinement in a hospital intensive-care unit for any covered illness or accident from the first day of coverage.***

**Certificates** - Certificates under this plan are issued on a guaranteed basis only at the time of the initial enrollment. A completed Evidence of Insurability form is required for late entrants into the group plan.

**Eligibility** - Family members eligible for coverage include: you, your spouse or domestic partner; and your children.

**Portability Privilege** - Allstate Benefits will provide portability coverage, subject to these provisions. Such coverage will not be available for you, unless: coverage under the policy terminates under the General Provision entitled "Termination of Coverage," we receive a written request and payment of the first premiums for the portability coverage not later than 63 days after such termination and the request is made for that purpose. No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

**Termination of Coverage** - As long as you are insured, your coverage under the policy ends on the earliest of: the date the policy is canceled, the last day of the period for which you made any required premium payments, the last day you are in active employment except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision, the date you are no longer in an eligible class, or the date your class is no longer eligible.

Allstate Benefits will provide coverage for a payable claim incurred while you are covered under the policy. If your spouse is a covered person, the spouse's

coverage ends upon valid decree of divorce or your death. If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death. If your child is a covered person, the child's coverage ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent.

Coverage does not terminate on an incapacitated dependent child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the coverage; and
3. is chiefly dependent upon you for support and maintenance.

Dependent coverage continues as long as the coverage remains in force and the dependent remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child's attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility. If Allstate Benefits accepts a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will be refunded, coverage will terminate and claims will not be paid.

**Limits, Exclusions, and Exceptions** - We do not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12-month period beginning on the date that person became a covered person. This exclusion will not apply to your newborn child, adopted child or foster child under the age of 18 if Allstate Benefits is notified within 31 days of the child's birth or date of placement. A Pre-Existing Condition is a disease or physical condition for which medical advice or treatment was recommended or received from a member of the medical profession within the 12-month period prior to the effective date of coverage. Allstate Benefits does not pay for any loss except for losses due directly from cancer or specified disease. We do not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. For the Surgery, New or Experimental Treatment and Prosthesis Benefits, if specific charges are not obtainable as proof of loss, Allstate Benefits will pay 50% of the applicable maximum for the benefits payable. Treatment must be received in the United States or its territories.

**Intensive Care Exclusions and Limitations** - The Hospital Intensive Care Unit Confinement benefit does not pay for intensive care if a covered person is admitted because of an attempted suicide, intentional self-inflicted injury, intoxication or being under the influence of drugs not prescribed or recommended by a physician, or alcoholism or drug addiction. Allstate Benefits does not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. Progressive care units, sub-acute intensive care units, intermediate care units, and private rooms with monitoring, step-down units and any other lesser care treatment units do not qualify as hospital intensive care units. We do not pay for step-down hospital intensive care unit confinement if a covered person is

admitted and confined in the following type of units: telemetry or surgical recovery rooms, post-anesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency rooms or outpatient surgery units, beds, wards, or private or semi-private rooms with or without telemetry monitoring equipment, an emergency room, labor or delivery rooms, or other facilities that do not meet the standards for a step-down hospital intensive care unit. We do not pay this benefit for continuous hospital intensive care unit confinements or continuous step-down hospital intensive care unit confinements that occur during a hospitalization that begins before the effective date of coverage. We do not pay for ambulance if paid under the cancer and specified disease ambulance benefit.

**Coverage Subject to the Policy** - The coverage described in the certificate of insurance is subject in every way to the terms of the policy that is issued to the policyholder (your employer). It alone makes up the agreement by which the insurance is provided. The group policy may at any time be amended or discontinued by agreement between Allstate Benefits and the policyholder. Your consent is not required for this. Allstate Benefits is not required to give you prior notice.

**The policy is Limited Benefit Cancer and Specified Disease Insurance.** This is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from American Heritage Life Insurance Company. Subject to COBRA continuation of coverage.

**This coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.** This material is valid as long as information remains current, but in no event later than April 15, 2018. Group Cancer and Specified Disease benefits are provided by policy **GVCP3**, or state variations thereof. This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy sets forth in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, contact your Allstate Benefits Representative. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificate issued.



**Allstate**<sup>®</sup>  
Benefits

*Allstate Benefits is the marketing name used by  
American Heritage Life Insurance Company  
(Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation.*

# *Allstate Benefits Monthly Rates*

## ***Low Option without Optional Benefits***

Insureds	Monthly Rates
<i>Employee</i>	<i>\$20.07</i>
<i>Employee + Child(ren)</i>	<i>\$27.71</i>
<i>Employee + Spouse</i>	<i>\$30.96</i>
<i>Family</i>	<i>\$38.57</i>

## ***Low Option with Optional Benefits***

Insureds	Monthly Rates
<i>Employee</i>	<i>\$26.06</i>
<i>Employee + Child(ren)</i>	<i>\$36.81</i>
<i>Employee + Spouse</i>	<i>\$41.50</i>
<i>Family</i>	<i>\$52.23</i>

## ***Mid Option with Cancer Initial Diagnosis***

Insureds	Monthly Rates
<i>Employee</i>	<i>\$29.75</i>
<i>Employee + Child(ren)</i>	<i>\$42.16</i>
<i>Employee + Spouse</i>	<i>\$47.02</i>
<i>Family</i>	<i>\$59.39</i>

## ***High Option without Optional Benefits***

Insureds	Monthly Rates
<i>Employee</i>	<i>\$31.09</i>
<i>Employee + Child(ren)</i>	<i>\$43.65</i>
<i>Employee + Spouse</i>	<i>\$47.51</i>
<i>Family</i>	<i>\$60.04</i>

## ***High Option with Optional Benefits***

Insureds	Monthly Rates
<i>Employee</i>	<i>\$37.08</i>
<i>Employee + Child(ren)</i>	<i>\$52.75</i>
<i>Employee + Spouse</i>	<i>\$58.05</i>
<i>Family</i>	<i>\$73.70</i>

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# *Aflac Critical Illness Insurance*

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**Effective Date: July 1, 2014**

- **Guaranteed Issue Amounts: Employee- \$10,000                      Spouse- \$5,000**

*The Aflac coverage described in this booklet is subject to plan limitations, exclusions, definitions, and provisions. For detailed information, please see the plan brochure, as this booklet is intended to provide a general summary of the coverage. This overview is subject to the terms, conditions, and limitations of policy series CAI2800.*

## **What is Aflac critical illness insurance? Why should I consider it?**

Aflac critical illness insurance provides lump sum benefits upon the diagnosis of each covered critical illness or event, including the following:

- Major Organ Transplant
- End-Stage Renal Failure
- Stroke
- Coma
- Paralysis
- Burns
- Loss of Sight
- Loss of Hearing
- Loss of Speech
- Heart Attack  
(Coronary Artery Bypass Surgery)
- Specific Heart Procedures

Any of these diagnoses or events would be life-changing. While major medical insurance can help with the costs of treatment, what about the out-of-pocket expenses that pile up while you or a loved one is out of work as a result of a covered critical illness? Aflac critical illness insurance benefits are paid directly to you (unless otherwise assigned) to use as you see fit. You can use the benefits to help with mortgage or rent payments, groceries, car payments—however you like.

## **What are some of the highlights of the Aflac critical illness plan?**

- An annual Health Screening Benefit is included.
- Spouse coverage is available.
- Benefit amounts range from \$5,000 to \$50,000 for employees. The benefit amount for spouses is \$5,000 to \$25,000.
- Each dependent child is covered at 50% of the primary insured's amount at no additional charge.
- Coverage may be guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Your premiums are paid through the convenience of payroll deduction.
- Your plan is portable (with certain stipulations). That means you may be able to take your coverage with you if you leave your job.

**Underwritten by Continental American Insurance Company**

*A proud member of the Aflac family of insurers*

## **Am I eligible for Aflac critical illness coverage? What about my family?**

You are eligible to apply for Aflac critical illness coverage if you:

- o Are between the ages of 18 and 69;
- o Are a full-time, benefit-eligible employee;
- o Are working at least 30 hours per week;
- o Are not a seasonal or temporary employee.

Your spouse must be between the ages of 18 and 69 to be eligible for coverage, and dependent children must be younger than age 26.

## **What core benefits does the Aflac critical illness plan feature?**

### **• First Occurrence Benefit**

After the waiting period, you may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

### **• Additional Occurrence Benefit**

After the waiting period, you may receive benefits for each different covered critical illness. Dates of diagnosis must be separated by at least six months.

### **• Reoccurrence Benefit**

You may receive benefits for the recurrence of any covered critical illness. Dates of diagnosis must be separated by at least 12 months.

### **• Heart Benefit**

After the waiting period, you may receive benefits for the following covered heart surgeries and procedures:

- o Coronary Artery Bypass Surgery (reduces the benefit for heart attack)
- o Mitral valve replacement or repair
- o Aortic valve replacement or repair
- o Surgical treatment of abdominal aortic aneurysm
- o AnjioJet clot busting\*
- o Balloon angioplasty (or balloon valvuloplasty)\*
- o Laser angioplasty\*
- o Atherectomy\*
- o Stent implantation\*
- o Cardiac catheterization\*
- o Automatic implantable (or internal) cardioverter defibrillator (AICD)\*
- o Pacemaker insertion\*

*\*Benefits for these procedures are payable at a percentage of your maximum benefit and will reduce the benefit amounts payable for other covered heart procedures.*

- **Health Screening Benefit**

After the waiting period, you may receive a maximum of \$100.00 for any one covered screening test per calendar year (regardless of the test results). This benefit is payable for you (the employee) and your covered spouse, not for dependent children. Covered screening tests include the following:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test, blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermograph

**What else do I need to know about the Aflac critical illness plan?**

You should know that the plan includes:

- **A 30-day waiting period.** This means that no benefits are payable for any insured before coverage has been in force 30 days from your effective date of coverage.
- **A pre-existing condition limitation.** A pre-existing condition is a sickness or physical condition that, within the 12 month period before your plan's effective date, resulted in the insured's receiving medical advice or treatment. No benefits are payable for any condition or illness starting within 12 months of an insured's effective date that is caused by, contributed to, or resulting from a pre-existing condition.
- **Certain exclusions.** No benefits are payable for loss resulting from:
  - o Intentionally self-inflicted injury or action;
  - o Suicide or attempted suicide while sane or insane;
  - o Illegal activities or participation in an illegal occupation;
  - o War, whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;
  - o Substance abuse; or
  - o Diagnosis and/or treatment received outside the United States.

***Aflac Critical Illness Insurance Plan  
Employee and Spouse Monthly Rates***

**NON-TOBACCO - Employee Monthly**

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
<b>18-29</b>	\$5.35	\$7.20	\$9.05	\$10.90	\$12.75	\$14.60	\$16.45	\$18.30	\$20.15	\$22.00
<b>30-39</b>	\$6.55	\$9.60	\$12.65	\$15.70	\$18.75	\$21.80	\$24.85	\$27.90	\$30.95	\$34.00
<b>40-49</b>	\$9.70	\$15.90	\$22.10	\$28.30	\$34.50	\$40.70	\$46.90	\$53.10	\$59.30	\$65.50
<b>50-59</b>	\$13.45	\$23.40	\$33.35	\$43.30	\$53.25	\$63.20	\$73.15	\$83.10	\$93.05	\$103.00
<b>60-69</b>	\$19.50	\$35.50	\$51.50	\$67.50	\$83.50	\$99.50	\$115.50	\$131.50	\$147.50	\$163.50

**NON-TOBACCO - Spouse Monthly**

	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
<b>18-29</b>	\$5.35	\$6.28	\$7.20	\$8.13	\$9.05	\$9.98	\$10.90	\$11.83	\$12.75
<b>30-39</b>	\$6.55	\$8.08	\$9.60	\$11.13	\$12.65	\$14.18	\$15.70	\$17.23	\$18.75
<b>40-49</b>	\$9.70	\$12.80	\$15.90	\$19.00	\$22.10	\$25.20	\$28.30	\$31.40	\$34.50
<b>50-59</b>	\$13.45	\$18.43	\$23.40	\$28.38	\$33.35	\$38.33	\$43.30	\$48.28	\$53.25
<b>60-69</b>	\$19.50	\$27.50	\$35.50	\$43.50	\$51.50	\$59.50	\$67.50	\$75.50	\$83.50

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**TOBACCO - Employee Monthly**

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
<b>18-29</b>	\$6.30	\$9.10	\$11.90	\$14.70	\$17.50	\$20.30	\$23.10	\$25.90	\$28.70	\$31.50
<b>30-39</b>	\$8.35	\$13.20	\$18.05	\$22.90	\$27.75	\$32.60	\$37.45	\$42.30	\$47.15	\$52.00
<b>40-49</b>	\$15.80	\$28.10	\$40.40	\$52.70	\$65.00	\$77.30	\$89.60	\$101.90	\$114.20	\$126.50
<b>50-59</b>	\$23.15	\$42.80	\$62.45	\$82.10	\$101.75	\$121.40	\$141.05	\$160.70	\$180.35	\$200.00
<b>60-69</b>	\$34.10	\$64.70	\$95.30	\$125.90	\$156.50	\$187.10	\$217.70	\$248.30	\$278.90	\$309.50

**TOBACCO - Spouse Monthly**

	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
<b>18-29</b>	\$6.30	\$7.70	\$9.10	\$10.50	\$11.90	\$13.30	\$14.70	\$16.10	\$17.50
<b>30-39</b>	\$8.35	\$10.78	\$13.20	\$15.63	\$18.05	\$20.48	\$22.90	\$25.33	\$27.75
<b>40-49</b>	\$15.80	\$21.95	\$28.10	\$34.25	\$40.40	\$46.55	\$52.70	\$58.85	\$65.00
<b>50-59</b>	\$23.15	\$32.98	\$42.80	\$52.63	\$62.45	\$72.28	\$82.10	\$91.93	\$101.75
<b>60-69</b>	\$34.10	\$49.40	\$64.70	\$80.00	\$95.30	\$110.60	\$125.90	\$141.20	\$156.50

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Note: If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands.

Continental American Insurance Company • 2801 Devine Street • Columbia, South Carolina 29205

Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under this plan could be assigned. This means that you may not receive any of the benefits in the plan.

As a result, please check to the coverage in all health insurance policies you already have or may have before you buy this insurance to verify the absence of any assignments or liens.

**800.433.3036 | [aflacgroupinsurance.com](http://aflacgroupinsurance.com)**

# *AUL Short-Term Disability Plan*

**Effective Date: July 1, 2014**

***Why do you need Disability Insurance? Consider this . . .***

**Statistics show you are much more likely to be injured in an accident than to die from one.**

- A fatal injury occurs every 5 minutes, and a disabling injury occurs every 1.5 seconds.<sup>1</sup>
- There is a death caused by a motor vehicle crash every 12 minutes; there is a disabling injury every 14 seconds.<sup>1</sup>
- In the home, there is a fatal injury every 16 minutes and a disabling injury every 4 seconds.<sup>1</sup>

**While many people survive accidental injuries, many others live with serious illnesses.**

- In the United States, men have a little less than a 1-in-2 lifetime risk of developing cancer; for women the risk is a little more than 1-in-3. The five-year relative survival rate for all cancers combined is 63%.<sup>2</sup>
- One in five males and females has some form of cardiovascular disease. High blood pressure is the most common form of cardiovascular disease.<sup>3</sup>
- More than 35 million Americans are now living with chronic lung diseases, such as asthma, emphysema, and chronic bronchitis.<sup>4</sup>

**Advances in medicine are allowing us to live longer. However, recovery from a serious illness or injury often requires time away from work.**

- In the last 20 years, deaths due to the big three (cancer, heart attack, and stroke) have gone down significantly. But disabilities due to those same three are up dramatically! Things that use to kill now disable.<sup>5</sup>

***You have life insurance, home insurance, and automobile insurance.  
But is your income insured?***

1 National Safety Council, Injury Facts, 2003 Edition

2 American Cancer Society, Cancer Facts & Figures 2004

3 American Heart Association, Heart Disease and Stroke Statistics – 2004 Update

4 American Lung Association, Lung Disease Data 2003

5 National Underwriter, May 2002

***Class Description***

All Full-Time Eligible Employees working a minimum of 20 hours per week, electing to participate in the Voluntary Short Term Disability Insurance

***Disability***

You are considered disabled if, because of injury or sickness, you cannot perform the material and substantial duties of your regular occupation. You are not working in any occupation and are under the regular attendance of a Physician for that injury or sickness.

***Monthly Benefit***

You can choose a benefit in \$100 increments up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of \$2,000. The minimum monthly benefit is \$500.

***Elimination Period***

This means a period of time a disabled Employee must be out of work and totally disabled before weekly benefits begin; seven (7) consecutive days for a sickness and zero (0) days for injury.

***Benefit Duration***

This is the period of time that benefits will be payable for disability. You can choose a maximum STD benefit duration, if continually disabled, of thirteen (13) weeks.

***Basis of Coverage***

24 Hour Coverage, on or off the job

***Maternity Coverage***

Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion.

***STD Pre-Existing Condition Exclusion***

3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to by, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person's Individual Effective Date. This Pre-Existing Condition limitation will be waived for all Persons who were included as part of the final premium billing statement received by AUL/ OneAmerica from the prior carrier and will be Actively at work on the effective date.

***Recurrent Disability***

If you resume Active Work for 30 consecutive workdays following a period of Disability for which the Weekly Benefit was paid, any recurrent Disability will be considered a new period of Disability. A new Elimination Period must be completed before the Weekly Benefit is payable.

### ***Annual Enrollment***

Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for \$500 to \$1000 monthly benefit without medical questions. Current participants may increase their coverage up to \$500 monthly benefit without medical questions. The maximum benefit cannot exceed 70% of basic monthly earnings and must be in \$100 increments.

Employees that elect to increase their Benefits Duration may do so only during the annual enrollment period subject to the pre-existing exclusion. The pre-existing exclusion will apply to the increased benefit duration.

### ***Portability***

Once an employee is on the AUL disability plan for 3 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to submit an application to port your coverage.

The Portability Privilege is not available to any Person that retires (when the Person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career).

### ***Exclusions and Limitations***

This plan will not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period.

*This information is provided as a summary of the product. It is not a part of the insurance contract and does not change or extend AUL's liability under the group policy. If there are any discrepancies between this information and the group policy, the group policy will prevail.*

#### **Customer Service**

800-553-5318

#### **Disability Claims**

866-258-8744

Fax: 207-591-3048

*Disability Claims Email: [claims@disabilityrms.com](mailto:claims@disabilityrms.com)*

**[www.employeebenefits.aul.com](http://www.employeebenefits.aul.com)**



**AMERICAN UNITED LIFE  
INSURANCE COMPANY®**  
*a ONEAMERICA® company*

## AUL Life Short-Term Disability Monthly Rates

**Benefit Duration:  
13 Weeks**

<b>Monthly Benefit</b>	<b>Monthly Premium</b>
\$500	\$10.36
\$600	\$12.43
\$700	\$14.50
\$800	\$16.57
\$900	\$18.64
\$1,000	\$20.71
\$1,100	\$22.78
\$1,200	\$24.85
\$1,300	\$26.92
\$1,400	\$28.99
\$1,500	\$31.07
\$1,600	\$33.14
\$1,700	\$35.21
\$1,800	\$37.28
\$1,900	\$39.35
\$2,000	\$41.42

# *AUL Long-Term Disability with Lump Sum*

**Effective Date: July 1, 2014**

## **LTD and Lump Sum Class Description**

All Full-Time Eligible Employees working a minimum of 20 hours per week, electing to participate in the Voluntary Long Term Disability Lump Sum Insurance

## **LTD Monthly Benefit**

You can choose to insure up to 60% of an Employee's covered basic monthly earnings to a maximum monthly benefit of \$2,000 in \$500 increments. The minimum benefit is \$500.

## **LTD Elimination Period**

This means a period of time a disabled Employee must be out of work and totally disabled before weekly benefits begin; 90 consecutive days for a sickness or injury.

## **LTD Benefit Duration**

This is the period of time that benefits will be payable for long term disability. Up to 5 years if disabled prior to age 61, or if disabled after age 61, as outlined below:

<b>Age When Total Disability Begins</b>	<b>Maximum Period Benefits are Payable</b>
Prior to Age 61	5 Years
61	Lesser of SSFRA or 5 Years
62	3.5 Years
63	3 Years
64	2.5 Years
65	2 Years
66	21 Months
67	18 Months
68	15 Months
Age 69 and Over	12 Months

## **LTD Total Disability Definition**

An Insured is considered Totally Disabled, if, because of an injury or sickness, he cannot perform the material and substantial duties of his Regular Occupation, is not working in any occupation and is under the regular care of physician. After benefit have been paid for 24 months, the definition of disability changes to mean the Insured cannot perform the material and substantial duties of any Gainful Occupation for which he is reasonably fitted for by training, education or experience.

### **LTD Mental & Nervous / Drug & Alcohol**

Benefit payments will be limited to benefit duration or 24 months, whichever is less, cumulative for each of these limitations for treatment received on an outpatient basis. Benefit payments may be extended if the treatment for the disability is received while hospitalized or institutionalized in a facility licensed to provide care and treatment for the disability.

### **Special Conditions**

Benefits for Disability due to Special Conditions, whether or not benefits were sought because of the condition, will not be payable beyond 24 months. Benefit payments for Special Conditions are cumulative for the lifetime of the contract.

**Lump Sum Benefit Amount:** Single payment of \$10,000

### **Lump Sum Elimination Period:** 90 days

This is the period of consecutive days the employee is disabled from their regular occupation beginning on the date of the disability. Because of an injury or sickness, you are unable to work at all or you are performing some of the substantial duties of your regular occupation for less than 80% of your regular hours.

### **Lump Sum Benefit Eligibility Period**

The period of consecutive days the employee is disabled beginning on the first day following the elimination period and continuing for 24 months. After satisfying the Elimination Period, the employee must be permanently and totally disabled during this time period in order to be entitled to the benefit.

### **Lump Sum Permanent and Totally Disabled**

Because of injury or sickness, you are expected to be unable: to work, engage in any activity for profit, receive income from a hobby or perform the substantial duties of any occupation for which you are reasonably fitted by training, education or experience on a full-time basis for a continuous period of not less than 24 months. You must also be under the regular attendance of a physician.

### **Other income Offsets**

AUL will not reduce your LTD or Lump Sum disability benefit with other disability income benefits that you might be receiving from AUL or external sources such as Social Security or other disability or income benefits you may receive, or be eligible to receive.

### **Waiver of Premium**

AUL will waive the premium payments for your coverage while you are disabled and will continue to be waived during the elimination period and the benefit eligibility period.

### **Pre-Existing Condition Exclusion**

3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to by, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person's Individual Effective Date.

This Pre-Existing Condition limitation will be waived for all Persons who were included as part of the final premium billing statement received by AUL/OneAmerica from the prior carrier and will be Actively at work on the effective date

Or

Continuity of Coverage will apply if the employee was insured under the employers prior group plan on the effective date of coverage. This means the benefit payable will be the lesser of the prior plan's or AUL's benefit.

### **Credit for the Satisfaction of the Pre-Existing Condition Exclusion Period**

This provision applies when a Person moves from an AUL group voluntary disability income insurance plan that provided the Person short term disability coverage similar to his coverage under the Group Policy offered by the Participating Unit. Credit will be given for the satisfaction of the Pre-Existing Condition exclusion period, or portion thereof, already served under the prior AUL group voluntary short term disability income insurance plan of coverage offered by the Participating Unit IF:

1. Coverage under the Group Policy is elected by the Employee during the Initial Enrollment Period; and
2. The Person changes from one AUL short term disability Plan to another AUL short term disability Plan under this Group Policy during a Scheduled Enrollment Period. The Person's Individual Effective Date of Insurance under the prior AUL group voluntary short term disability income insurance plan of coverage offered by the Participating Unit will be used when applying the Pre-Existing Condition exclusion or limitation period.

The Group Policy Pre-Existing Condition Limitation will not apply to a Person that was not subject to the prior AUL short term disability plan's Pre-Existing Condition Limitation.

### **Portability**

Once an employee is on the AUL disability plan for 3 months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to contact AUL and make application to port your coverage by calling 1.800.553.3522.

### **Annual Enrollment**

Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for \$500 or \$1000 monthly LTD benefit with Lump Sum without medical questions. The maximum benefit cannot exceed 60% of basic monthly earnings.

### **Exclusions and Limitations**

This plan will not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period.

<b>Voluntary Long Term Disability with Lump Sum Monthly Rates</b>					
<b>Employees...</b>	<b>Lump Sum Coverage Amount</b>	<b>\$500</b>	<b>\$1,000</b>	<b>\$1,500</b>	<b>\$2,000</b>
<b>Under 65</b>	\$10,000	\$15.40	\$21.80	\$28.20	\$34.60
<b>Age 65-69</b>	\$7,000	\$12.70	\$19.10	\$25.50	\$31.90
<b>Age 70-74</b>	\$4,500	\$10.45	\$16.85	\$23.25	\$29.65
<b>Age 75-79</b>	\$3,000	\$9.10	\$15.50	\$21.90	\$28.30
<b>Age 80-84</b>	\$2,500	\$8.65	\$15.05	\$21.45	\$27.85
<b>Age 85-89</b>	\$2,000	\$8.20	\$14.60	\$21.00	\$27.40
<b>Age 90 and over</b>	\$1,500	\$7.75	\$14.15	\$20.55	\$26.95

**Customer Service**

800-553-5318

**Disability Claims**

866-258-8744

Fax: 207-591-3048

Disability Claims Email: [claims@disabilityrms.com](mailto:claims@disabilityrms.com)

**[www.employeebenefits.aul.com](http://www.employeebenefits.aul.com)**



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INSURANCE COMPANY®**  
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This information is provided as a Benefit Outline. It is not a part of the insurance policy and does not change or extend American United Life Insurance Company's liability under the group Policy. Employers may receive either a group Policy or a Certificate of Insurance containing a detailed description of the insurance coverage under the group Policy. If there are any discrepancies between this information and the group Policy, the Policy will prevail.

# *AUL Group Term Life Plan*

*Effective Date:* July 1, 2014

***Class Description***

All Full-Time and permanent Part-Time Eligible Employees working a minimum of 20 hours per week, electing Voluntary Life/AD&D Coverage

***Life Amount***

Increments of \$10,000 to a maximum of the lesser of Five Times Annual Base Earnings or \$100,000, with a minimum benefit of \$10,000.

**AD&D Principal Sum Amount:** Matches Life Amount

**Guaranteed Issue Amount:** \$100,000

***Reductions:***

The Life Amount and AD&D Principal Sum will begin reducing to a percentage of the amounts shown above when the Employee reaches age 65. The percentage of coverage remaining at the Employee's attained age will be as shown as follows:

Employee's Age	Percentage of Benefit
65-69	65%
70-74	45%
75-79	30%
80-84	20%
85-89	15%
90+	10%

***Dependent Life Benefit***

**Employee's Spouse:** \$5,000.

- Spouse Guarantee Issue Amount: \$5,000

***Child(ren):***

- 6 months to 19 years (26 if a full-time unmarried student) \$5,000
- Child – Live birth to 6 months \$1,000

***Accidental Death and Dismemberment***

While insured under the Policy, if the Employee has an accident which results in a loss specified below, AUL will pay the amount shown for such loss; provided the loss occurs within 365 days of the accident and AUL receives acceptable proof of loss.

<b>Loss</b>	<b>Amount Payable</b>
Life	Principal Sum
Both Hands or both feet or sight of both eyes	Principal Sum
Severe Burns	Principal Sum
Speech and hearing	Principal Sum
One hand and one foot	Principal Sum
One hand and sight of one eye	Principal Sum
One foot and sight of one eye	Principal Sum
Quadriplegia or Loss of use of upper and lower limbs or the body	Principal Sum
Paraplegia or Loss of use of both lower limbs of the body	½ Principal Sum
Hemiplegia or Loss of use of upper and lower limbs on the same side of the body	½ Principal Sum
Sight of one eye, one hand, or one foot	½ Principal Sum
Speech or hearing	½ Principal Sum
Monoplegia or Loss of use of one limb of the body	¼ Principal Sum
Thumb and index finger	¼ Principal Sum

***Accelerated Life Benefit “ALB”***

The Employee may request payment of either 25%, 50% or 75% of the Life Amount shown above if the Employee is diagnosed with a Terminal Condition, as defined in the Certificate of Insurance.

***Portability / Conversion***

If the Employee's Life Insurance or a portion of it ceases, the Employee may be entitled to portability if they apply within 31 days of termination. The Employee can contact AUL, or refer to his or her Certificate of Insurance for specific details of this provision.

***Accidental Death and Dismemberment Exposure Benefit***

If an Employee is unavoidably exposed to heat or cold as a direct result of a covered accident, and as a direct result of the exposure, the Employee suffers a loss for which benefits would be payable under this Plan, an AD&D benefit will be paid. Any loss associated with exposure to heat or cold must occur within 365 days of the accident.

***Accidental Death and Dismemberment Disappearance Benefit***

If an Employee is an occupant in a vessel, vehicle, or plane at the time of accidental destruction, sinking, or disappearance of the vessel, vehicle, or plane and the Employee's body cannot be found within one year of the date of the accidental destruction, sinking, or disappearance, the Employee will be presumed to have died. AUL will only presume Accidental Death if:

- (a) there is no evidence to the contrary;
- (b) there is a determination by the appropriate governmental authorities or court issuing a valid and legally binding determination that the Employee has died;
- (c) a certified copy of the governmental authority findings or court order is provided to AUL; and
- (d) benefit would have been paid assuming a death certificate could have been issued if the body was recovered.

***Accidental Death and Dismemberment Repatriation Benefit***

If an Employee dies either greater than 200 miles away from his principal place of residence or is outside of the country at the time of Accidental Death, AUL may pay an additional Accidental Death Benefit. The Repatriation Benefit equals the lesser of:

- (a) Reasonable Expenses for transportation of the Employee's body to a funeral home or mortuary near the Employee's principal place of residence;
- (b) \$5,000; or
- (c) 10% of the Employee's AD&D Principal Sum shown in the Schedule of Benefits.

***Accidental Death and Dismemberment Child Higher Education Benefit***

The Child Higher Education Benefit will be no more than \$4,000 for each Eligible Student per Academic Year for Education Expenses. The cumulative benefit payments for all eligible students will not exceed the lesser of:

- (a) \$20,000; or
- (b) 10% of the Employee's AD&D Principal Sum shown in the Schedule of Benefits.

***Accidental Death and Dismemberment Child Care Benefit***

The Child Care Benefit will be no more than \$4,000 for each Eligible Child per calendar year for Child Care Expenses. The cumulative benefit payments for all eligible children will not exceed the lesser of:

- (a) \$20,000; or
- (b) 10% of the Employee's AD&D Principal Sum shown in the Schedule of Benefits.

***Waiver of Premiums for Total Disability***

AUL will waive further premium payments for the Employee's Life Amount if the Employee becomes Totally Disabled before age 60 while insured under the Policy, and remains continuously Totally Disabled for 6 months, and submits proof of Total Disability. There is a 24 month limitation on Waiver of Premium if the Total Disability is due to a Mental Illness and/or Drug and Alcohol abuse.

***Suicide Limitation***

The certificate of insurance contract contains a Two Year Suicide Limitation.

***Terminations***

The Individual Terminations Section in the Certificate of Insurance governs Terminations.

*This information is provided as a Benefit Outline. It is not a part of the insurance contract and does not change or extend American United Life Insurance Company's® liability under the group Policy. Employers will receive a Certificate of Insurance containing a detailed description of the insurance coverage under the group Policy. If there are any discrepancies between this information and the group Policy, the group Policy will prevail.*

<b>Employee Optional Term Life</b>	
<b>Amount of Coverage</b>	<b>Monthly Cost</b>
\$10,000	\$3.80
\$20,000	\$7.60
\$30,000	\$11.40
\$40,000	\$15.20
\$50,000	\$19.00
\$60,000	\$22.80
\$70,000	\$26.60
\$80,000	\$30.40
\$90,000	\$34.20
\$100,000	\$38.00

<b>Dependent Life Monthly Rate</b>	\$1.80*
*Rate is regardless of number of dependents	

# ***Texas Life Whole Life Policy -VPL-plus***

**Common Issue Date: August 1, 2014** (pending underwriting approval)

This **Voluntary Permanent Life Program** will allow you to purchase permanent life insurance for you and your eligible dependents.

VPL- plus is an individual permanent life insurance product specifically designed for employees and their families. It provides a guaranteed level premium and death benefit for the life of the policy, and you can keep the life insurance even after you retire.<sup>1</sup>

As an employee, you are eligible to apply if you have satisfied your employer's eligibility period. You may also apply for coverage on your spouse, children and grandchildren.<sup>2</sup>

## **WHY VOLUNTARY COVERAGE**

- Most employees are typically dependent on group term life insurance
- Today more adults than ever have only group life insurance obtained through their employers, but they carry the lowest average amount of coverage.
- On the other hand, adults with both individual life and group life policies have the highest life insurance protection.<sup>3</sup>
- Most term policies expire before paying a death claim
- When do you want a life insurance policy in force?
  - Answer: When you die
- Term is for IF you die; permanent is for WHEN you die

## **TEXAS LIFE'S VPL-plus**

- Portable, permanent life insurance through the convenience of payroll deduction
- Whole life chassis
- Strong guarantees<sup>1</sup>
- Popular features
- Coverage available for spouse, children and grandchildren<sup>2</sup>

## **VPL-plus: PORTABLE AND PERMANENT**

- Employee can keep policy, at same premium, if he/she retires or changes jobs
- Employee may apply for spouse, children and grandchildren at the worksite
- Permanent coverage: policy guaranteed to remain in force as long as necessary premiums are paid

## **VPL-plus: THE GUARANTEES EMPLOYEES WANT**

- Guaranteed level premium
- Guaranteed level death benefit<sup>1</sup>
- Guaranteed reduced paid-up insurance at retirement
- Guaranteed paid-up for face amount at age 70 (or after 20 years for insureds between ages 51 and 70)

12M203-C Non-Edu 2004 (exp0914) See the VPL-plus brochure for complete details. Policy PWLESV-NI-05

## **VPL-plus: CGI (EXPRESS ISSUE) UNDERWRITING**

### **Employee, spouse coverage require 3 health and employment related questions:**

- During the last six months, has the proposed insured been actively at work on a full-time basis, performing usual duties?
- During the last six months, has the proposed insured been absent from work due to illness or medical treatment for a period of more than five consecutive working days?
- During the last six months, has the proposed insured been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation therapy, dialysis treatment or treatment for alcohol or drug abuse?

### **Child coverage (ages 6 months -26 years old):<sup>2</sup>**

- During the last six months, has the proposed insured been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation therapy, dialysis treatment or treatment for alcohol or drug abuse?

### **Express Issue Maximums**

- Employee
  - Ages 17-49, \$100,000
  - Ages 50-65, \$50,000
  - Ages 66-70, \$10,000
- Spouse (if employee applies)
  - Ages 17-49, \$50,000
  - Ages 50-60, \$25,000
- Children - ages 6 months - 26 years \$25,000<sup>2</sup>
- Grandchildren - ages 6 months - 16 years \$25,000<sup>2</sup>

### **Simplified Issue<sup>4</sup>**

- Use if proposed insured wants amounts over Express Issue maximums
- Coverage is dependent on answers to health-related and other questions contained in the application
- Answer all underwriting questions
- Blood required for amounts in excess of \$100,000
- Rates are unisex
- Rates are unismoke

### **Accelerated Death Rider**

- Included on all policies (Employee, Spouse, Minor Children, Grandchildren)<sup>2</sup>
- Pays 92% of death benefit, (84% in Illinois) less \$150 (\$100 in Florida) processing fee, upon physician certified diagnosis of condition expected to result in death within 12 months (24 months in Illinois) (conditions and limitations apply).
- No extra charge for rider
- Policy **terminates** when rider is exercised

### **Waiver of Premium**

- Available for issue ages 17-55
- Benefit payable to insured through age 60
- Cost is included in premium

### **VPL-plus: Review**

- Permanent and portable when you change jobs or retire
- Non-participating Whole Life chassis (no dividends)
- Guaranteed level death benefit<sup>1</sup>
- Guaranteed level premium
- Guaranteed reduced paid-up insurance at retirement
- Premiums cease at age 70 (or after 20 years, ages 51-70)
- Waiver of Premium available issue ages 17-55
- Express Issue underwriting
- Unisex rates
- Unismoke rates
- Blood required for amounts over \$100,000
- Simplified issue for health reasons or for amounts over Express Issue maximums

<sup>1</sup>Guarantees are backed by the claims paying ability and financial strength of the issuing company.

<sup>2</sup>Policies not available on children & grandchildren in Washington.

<sup>3</sup>Generations at Risk LIMRA International (2008)

<sup>4</sup>We retain the right to require a medical exam.

Texas Life complies with all state laws regarding marriages, domestic and civil union partnerships, and legally recognized familial relationships.

*This brochure has been prepared to give you the highlights of coverage now being offered through your employer to meet your insurance needs. The details will be provided during your individual meeting with a qualified Texas Life Enrollment Representative. Those employees who wish to participate will be provided a personal policy that spells out all policy provisions.*

*If you have any questions regarding your Texas Life policy, please call  
(800) 283-9233 prompt #3.*

**TEXASLIFE** INSURANCE  
COMPANY  
Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

## ***Continuing Your Benefits***

### ***To Continue Your Medical, Dental, Vision, and/or FSA Plan***

*Under the group medical plan, dental plan, vision plan and your Flexible Spending Accounts, you and your covered dependents are eligible to continue coverage through COBRA. Upon termination, you will receive notification from Interactive Medical Systems (IMS) - your COBRA administrator - with premium and continuation options. Should you have any questions, you may contact IMS at 800-426-8739.*

### ***AUL Short-Term & Long-Term Disability***

*Portability: Once an employee is on the AUL disability plan for 3 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to submit an application to port your coverage.*

*The Portability Privilege is not available to any Person that retires (when the person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career).*

### ***To Convert Your Term Life Insurance***

*When you leave your employment, you may continue the existing group term coverage you have through your employer to a guaranteed issue individual policy. It is the responsibility of the employee to convert or port coverage. You must apply for continuation within 31 days from the date of termination. For more information and a quote, please contact American United Life at 800-553-5318. If you do not convert or port your group term life insurance, coverage will terminate when you leave your employer.*

***To Continue Other Policies***

*You may continue your Allstate Cancer, Assurity Cancer, Aflac Group Accident and Critical Illness and/or Texas Life Whole Life policies by having the premiums currently being deducted from your paycheck either drafted from your bank account or billed to your home.*

*For more information, contact*

*Allstate at 800-521-3535*

*Assurity at 866-289-7337*

*Aflac Group at 800-433-3036*

*Texas Life at 800-283-9233*

## ***Contact Information for Questions and Claims***

### ***BlueCross BlueShield of NC***

*Customer Service*

*877-258-3334*

*www.bcbsnc.com*

### ***Gilsbar***

*Gilsbar, Inc. Claims Department*

*PO Box 2947*

*Covington, LA 70434-2947*

*888-445-7227 x883*

*www.gilsbar.com*

*customercontactcenter@gilsbar.com*

### ***Ameritas Dental***

*Customer Service*

*800-487-5553*

*www.ameritasgroup.com*

### ***Community Eye Care***

*Claims Services*

*888-254-4290*

*Fax: 704-426-6044*

*www.communityeyecare.net*

*2359 Perimeter Pointe Parkway, Suite 150*

*Charlotte, NC 28208*

***Aflac***

*(CAIC a proud member of the Aflac family of insurers)*

*2801 Devine Street  
Columbia, SC 29205*

***Customer Service***

*800-433-3036*

*www.aflacgroupinsurance.com*

***Allstate Benefits***

*1776 American Heritage Life Drive  
Jacksonville, Florida 32224*

*For questions concerning your policy please call:*

*800-521-3535*

*For questions concerning your claim please call:*

*800-348-4489*

*or e-mail [claimsresearch@allstate.com](mailto:claimsresearch@allstate.com)*

***American United Life (AUL)***

*Claims Toll-Free Number*

*866-258-8744*

*Customer Service*

*800-553-5318*

***Texas Life Insurance Company***

*PO Box 830*

*Waco, TX 76703-0830*

*800-283-9233*

***Mark III Brokerage***

*211 Greenwich Rd*

*Charlotte, NC 28211*

*800-532-1044*

*www.markiiibrokerage.com/duplincountync*